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SOCIAL SECURITY ADVISORY COUNCIL RECOMMENDATIONS ON MEDICARE TRUST SOLVENCY

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

APRIL 9, 1984

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SOCIAL SECURITY ADVISORY COUNCIL RECOMMENDATIONS ON MEDICARE TRUST SOLVENCY

MONDAY, APRIL 9, 1984

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Bob Packwood presiding.

Present: Senators Packwood and Durenberger.

[The press release announcing the hearing and the statements of Senators Dole, Packwood, and Durenberger follow:]

[Press Release, Mar. 20, 1984]

FINANCE COMMITTEE RESCHEDULES HEARING TO RECEIVE SOCIAL SECURITY ADVISORY COUNCIL RECOMMENDATIONS ON MEDICARE TRUST SOLVENCY

Senator Robert J. Dole (R., Kans.), Chairman of the Senate Committee on Finance, announced today that the hearing which had been scheduled for Monday, March 26, 1984 at 2:00 p.m. has been rescheduled.

The hearing will now begin at 10:00 a.m. on Monday, April 9, 1984, in room SD-215 of the Dirksen Senate Office Building.

OPENING STATEMENT OF SENATOR BOB DOLE

I am particularly pleased to welcome today's witnesses. This committee has followed with tremendous interest the deliberations of the 1982 advisory council and we are anxious to examine in more detail their recommendations.

This hearing comes at a particularly important time for two reasons. First, we have just received the 1984 trustees report on the status of the three trust funds: Old age and survivors; disability and the medicare hospital insurance trust fund. Secondly, we are in the midst of hopefully the final resolution of the budget, which includes some incremental changes in medicare.

TRUSTEES REPORT

The news contained in the trustees report should come as no surprise to anyone. The social security retirement program is in much the same financial condition as projected last year after the enactment of the recommendations of the President's National Commission on Social Security Reform. The trustees' projections show reserves sufficient to keep benefits going out on time through the 1980's and well into the century. As long as reserves are low, as they will be for the next few years, however, Congress will have to monitor the program closely. But, barring unusually poor economic performance, social security should not run into trouble for quite some time. In the longer term, the trustees forecast that reserves will accumulate rapidly, beginning in the 1990's, which will help finance benefits when the baby-boom generation retires early in the next century. All in all, things look pretty good for social security.

Medicare is another matter. The news is equally unsurprising for medicare, and unfortunately it continues to be bad. The present financing schedule for the hospital

insurance trust fund is barely adequate to insure solvency through the end of this decade. Under both the intermediate II-A and II-B assumptions, the fund is exhausted in 1991.

The trustees continue to believe, while pointing out that the enactment of TEFRA in 1982 and the passage of the 1983 social security amendments helped the trust fund, that the future is bleak unless further changes are made.

In fact, they again pointed out, as they did last year, that the size of the problem requires dramatic action. The report suggests that in order to bring the hospital insurance program into close actuarial balance for the 25-year projection period under alternative II-B assumptions, either disbursements of the program will have to be reduced by 32 percent or income will have to be increased by 48 percent.

Our interests clearly will be with those interested in preserving the medicare trust fund, by making changes that are balanced among all aspects of the program.

ADVISORY COUNCIL RECOMMENDATIONS

In principle, the 1982 advisory council has taken an approach in addressing the problems faced by medicare that this Senator has long endorsed. They considered four general areas; financing, eligibility, benefit structure, and reimbursement. In doing so they recognized that no one change will solve the problem. Certainly we cannot expect the beneficiary to bear the full burden, nor can we expect it of the hospitals participating in the program or the physicians.

The solutions will require each side to give a little, keeping uppermost in mind our combined resolve to preserve this program.

THE PRINCIPLES OF REFORM

At the outset of our discussions we must recognize certain basic principles:

(1) Preserve access to care by low income elderly.

(2) Maintain a reimbursement system that encourages provider participation and continues to assure beneficiary access to mainstream health care.

(3) Maintain financial discipline imposed by the trust fund structure.

CONCLUSION

The Senator from Kansas believes we can reach agreement on a series of recommendations before medicare goes broke. But in order to do so, the discussions must begin now. I am not wedded to any one solution, nor do I believe this committee has already made its decision. So it is with a great deal of pleasure that I welcome these witnesses who will help us identify options for change.

In addition, let me note that I am submitting for the record a letter submitted to us by Mr. Alvin E. Heaps, president, Retail, Wholesale and Department Store Union, a member of the 1982 advisory council. The letter outlines the minority views prepared by Mr. Heaps and Mr. Stan Arnold, Secretary Treasurer of the Michigan Building and Construction Trades, also a member of the advisory council.

Unfortunately, prior commitments made it impossible for either Mr. Heaps or Mr. Arnold to testify today. But let me assure them that their views will be given our serious consideration.

OPENING STATEMENT OF SENATOR BOB PACKWOOD

WASHINGTON.—Implementation of home health care programs proposed in legislation by Senator Bob Packwood, R-Oregon, could relieve part of the burden on the nearly-insolvent Medicare system, Packwood said at this morning's Finance Committee hearing on the viability of Medicare.

The 1982 Advisory Council on Social Security unanimously recommended that:

"The growing cost of hospital and nursing home care has prompted studies of the costs and cost-effectiveness of care delivered in alternative settings by both the public and private sectors. Some studies have shown that targeting the population offered home care services as an alternative to institutionalization is a more efficient and appropriate way to deliver care. The Advisory Council on Social Security suggests that in developing a comprehensive long term care program, the Secretary of Health and Human Services be guided by the results of these studies."

"Based on that, I believe we should move forward now with long term care legislation," Packwood said, referring to S. 1244, the Independent Community Care Act he introduced with Senator John Heinz, R-Pa., last year.

"The goal of my bill is to keep people out of hospitals and nursing homes and at home, where they will recover faster in familiar surroundings and with friends and

family at hand. I believe this will cost less and result in overall savings for our overburdened health care system."

Packwood's bill would create statewide demonstration programs in four states for four years to provide acute and home health services. Seniors would receive Medicare Part A and B services plus the following new services: homemaker/home health aide, adult day care, respite care, individual assessment and treatment and coordination of services.

Senator PACKWOOD. The committee will come to order, please. This morning we are starting the first of what may be over the next few months or years a series of hearings on the problems facing medicare, both in terms of health delivery and in terms of cost. Today we will focus heavily on cost, on the trust fund, and its projections for the future. Unfortunately, those financial projections appear to be rather gloomy if the testimony of the witnesses today is at all even close to accurate, and I fear that it is. There are not very many ways that you can address the kind of problem we face. Either you increase the income or you reduce the benefits, and if there is some other way—or if there is someone else who has another way—to address the trust fund problem, I can assure you that the committee would be very happy to hear from you.

For the present, I feel we are forced to face one of two basic remedies. Is there a way to increase revenue that is fair and satisfactory in terms of the quantity of care needed. If not, is there a way to pay our costs without having to unduly restrict benefits. And having read the statements this morning, I can tell that's specifically what the witnesses are going to address themselves to today.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman. I would like to join you in welcoming our doomsayers and some problem solvers to the hearing today and compliment the actuaries for starting way back in 1975, before I ever thought of coming to the U.S. Senate, to alert us to the deficit potential for the medicare trust fund. It seems to me fairly obvious, that as the actuaries and CBO both point out, that the simple options are either to increase the income to the trust fund by a substantial amount—I think the actuary will testify to 48 percent—or to decrease outlays by 32 percent. Nobody is going to testify as to exactly how we do that, other than Governor Bowen on behalf of the Advisory Council. It strikes me from the series of hearings and activities that we have undertaken over the last few years that few of our advisors, or the advisors to the Advisory Commission, and nobody on this committee wants to recommend the course that we took primarily on social security reform, and that is just to raise revenues.

And that leaves us with the problem of reducing outlays, and the question before this committee and before the Advisory Commission was how are you going to do that. For the period of fiscal 1982 to 1987, this committee has approved outlay reductions in part A of a rather substantial amount—I don't have those dollar figures in front of me—and we have also recommended reductions in outlays in part B by some substantial amount. I know the current proposal we will start debating this afternoon has a total of $9 billion over the 1984-87 time frame in reduction.

But in addition to that, we have put in place with the help of our colleagues on the House side some rather, what might be perceived as revolutionary reforms in the way that we pay for medicare. We

also have done some benefit expansion in the last couple of years—hospice comes to mind—and there are some others. But we have not done a great deal in reforming either the entitlements or the insurance section of medicare. I think Governor Bowen will give us some suggestions today about the course we ought to follow in that regard. One of the points, Mr. Chairman, that I made in my testimony to the Advisory Commission is that my instincts tell me that we have to keep in mind that this is not the last hearing we are going to have, nor are the recommendations that the Advisory Commission gives us the last set of recommendations that they as a Commission or individually as members of that Commission are going to give us. And that is because the swords that we use to slay the dragon of medicare bankruptcy when it finally reaches the brink in the 1990's I suspect will be very different from what we would use if we were going to do the slaying today as we did social security bankruptcy slaying in 1983. And that is because the health care delivery system out there in America 5 or 10 years from now is going to look very different from what it looks today.

Health care is changing dramatically. Prospective payment. Health maintenance organizations. Preferred provider organizations. Emergency centers. Surgery centers. Our whole vocabulary to describe that system is changing.

We are seeing increased patient choice, and provider competition sweep across the country. Preventive health care and wellness insurance with their financial rewards are springing up all over America. Vouchers for competitive health plans are demonstrating consistent success where they are in place in this country. Social HMO's, if we can ever get them out of OMB. Long-term care insurance, which we never thought we would see, is starting to spring up. Community-based long-term care services under the guidance of 50 States in this country show us further promise in changing the way we meet the health care needs of elderly Americans. The Advisory Council has done a very good job of taking a snapshot of our present predicament. Their recommendations deserve careful review and consideration, and I think we ought to do what we can with their suggestions, but recognize the needs, circumstances, opportunities, and real workable solutions change over time.

To me, it is like rushing in today to fix a broken arm that isn't going to break until 7 years from now. My suggestion will be that we wait to see if we can prevent the break, and if it occurs, see what kind of tools are coming on-line to fix it. Mr. Chairman, Governor Bowen and the other Council members know that I agree with some of their recommendations and disagree with others. They indicated that I testified before the Council last November, and rather than reviewing my remarks here today, I will ask that my statement before the Advisory Council be made part of the record.

Senator PACKWOOD. Without objection.

STATEMENT BY SENATOR DAVE DURENBERGER TO THE ADVISORY COUNCIL ON SOCIAL SECURITY, NOVEMBER 3, 1983

First, let me commend all of you for the fine work you've done on the Advisory Council. Figuring out how to save Medicare is no easy task, especially given that every recommendation has political ramifications. It's much easier for policy-makers

to postpone any action until we are on the brink of disaster—that's what we did with social security—so I appreciate your efforts to generate discussion and present options before Medicare reaches that critical point.

I'd like to spend what time I have with you today to share with you my perspective on the Medicare program and react to some of your proposals.

It's important to keep in mind, I think, that the viable reforms for Medicare in 1988 may be very different from what they are today. That's because the health care world will be very different five years from now. The health care world is changing dramatically. These changes mean that by the time Medicare insolvency is upon us our options may be far different. That makes your task more difficult. And it may suggest that you should revisit your recommendations from time to time.

DRGs are a big reason for the change. Prospective payment fundamentally changes the economic incentives for health care providers. DRGs are only in the second month of a three-year phase-in, but the effect is already dramatic. Ask Sam Howard about the impact on hospital planning and management. For the first time, hospitals are aggressively pursuing management strategies that maximize efficiency.

In order to sustain the progress being made, I believe the DRG system must be expanded. That doesn't mean, though, that we should create a separate prospective payment system for every provider class. To do so would only further fragment an already fragmented health care system. No, what we must do is work to consolidate our payment for services into a single payment. In other words, we must expand the present DRG payment to include physicians, home health, skilled nursing, and other levels of care.

No doubt many of you have heard about how hospitals are responding to the price-sensitive world of DRGs. One hospital in my home state has built its own hotel attached to the hospital. That way, patients can be admitted to the hotel the night before admission, at $30 a night rather than to the hospital at a rate of $250 a night. Prospective payment rewards such behavoir. Likewise, many hospitals are negotiating with nursing homes so that patients can be moved from an acute-care hospital bed to a less intensive—and less expensive—nursing home bed as soon at it is appropriate.

The new prospective payment system will obviously facilitate vertical integration—both in terms of financing and in terms of better patient care. To reward and further stimulate this development, we need to broaden the hospital DRG to include payment for other forms of care. We should start by expanding the hospital DRG to include payment for skilled nursing facility care. That way, each hospital will be responsible for directly providing or contracting for skilled nursing care. Decisions about when such care is appropriate and what price should be paid for it will be left to hospitals and their physicians.

We shouldn't stop there. Hospital DRGs should be further expanded to include payment for home health care, hospice care, and physician care. I conceive a single DRG payment that ultimately covers an entire spell-of-illness, from the time a patient enters the hospital to the time a patient is rehabilitated in the home. This single payment will cover all services, and will give hospitals and physicians a strong incentive to manage total patient care.

Separate prospective payment systems for separate providers does nothing to control overall utilization in the system. Only a single, comprehensive payment assures that substitution of services takes place at the right time and at the right price. As far as I'm concerned, it's vitally important that we continue to build this kind of prospective payment system.

I am not wedded to paying the hospital this spell-of-illness DRG. After all, it's physicians who manage patient care. If physicians are willing to step forward and receive the consolidated payment, all the better. They can then develop contractual arrangements with hospitals, home health agencies, nursing homes and other providers. And physicians can then manage both the services and the financing. If, however, physicians are not willing to accept the payment, it should be made to the hospital.

I expect that a move toward an expanded prospective payment system will show providers that they can work together in managing total patient care. And as providers become more comfortable working with one another in providing services and containing costs, participation in Medicare's voluntary voucher will become more and more attractive.

As you all know, Congress passed a provision as part of the 1982 Tax Equity and Fiscal Responsibility Act to create a private sector option under Medicare. Beginning early next year, beneficiaries will have the option of using their Medicare entitlement to purchase coverage in the private sector. A voucher carries prospective

payment to its logical conclusion. Even a spell-of-illness DRG has its shortcomings: Payment under DRGs is activated at admission, which encourages unnecessary or inappropriate admissions. And the patient is largely left out of any rewards that accrue under DRGs.

A voucher consolidates DRGs and outpatient services into a single, annual capitated payment. Beneficiaries use their voucher to purchase coverage in a private health plan. Health plans that keep their patients healthy and their costs down, that substitute services at the right time and right price—these plans will be very successful in attracting beneficiaries. A voluntary voucher rewards the individual patient for selecting a cost-effective health plan. And it rewards the health provider for delivering cost-effective care. One of the short-comings of the voluntary voucher is that there just aren't that many private health plans out there that will qualify for participation. The definition of a competitive medical plan limits participation to plans like HMOs and PPOs. Over time, I expect the definition of participating plans to be broadened. For now, however, the limited definition serves to both phase in the program and reward those kinds of plans we know stimulate price competition. As the market develops, participation will be broadened.

I expect that the DRG system will greatly stimulate the development of competitive medical plans. We're already seeing remarkable interest in PPOs around the country. I fully expect that by the time Congress is ready to undertake a serious national debate about the bankruptcy of Medicare, a solution based on vouchers will be far more acceptable and attractive. Beneficiaries will like the choice. Providers will prefer the market. And federal expenditures will be far more predictable and controllable.

In other words, although capitation or a Medicare voucher may not appear to be a very viable solution to Medicare's woes at this time, I believe it will become much more attractive as time goes on. And I believe we have enough time to show that such an approach can work.

In the meantime, though, there are concrete steps that can be taken to reform Medicare, many of which you have addressed and will, I expect, adopt.

First, I should commend you for adopting a recommendation to oppose any further extension of Medicare coverage to individuals suffering from specific diseases and in need of special treatments. As you know, there is currently a great deal of interest in extending Medicare coverage to those needing liver transplants. I firmly believe that such measures only serve to further cloud the causes and possible solutions for Medicare cost growth. If the Federal government decides to pay for extraordinary treatments, they should be paid for separate from Medicare. For example, a separate Catastrophic Health Fund could be created to pay for heart transplants, liver transplants, and artificial organs. I've proposed just such a fund in recent speeches. Separate funding keeps American citizens and politicians from confusing the cost of health care for our elderly with the cost of extraordinary treatments. Separate funding also keeps the cost of extraordinary care from masking any success we might have in controlling Medicare costs.

Second, I'm happy to see that the Council is pursuing a restructuring of the Medicare benefit. I intend to introduce my own legislation to restructure the Medicare benefit very soon. Like you, I believe it is vitally important that an out-of-pocket limit be placed on beneficiary expenditures. After all, catastrophic expense protection is what health insurance is all about. It really shouldn't be too surprising that risk-averse senior citizens on fixed incomes rush out to buy Medigap policies that provide protection against catastrophe. If Medicare covered catastrophic expenses, we wouldn't see hundreds of millions of dollars wasted on unnecessary Medigap insurance.

In my bill, I establish a combined part A and B out-of-pocket expenditure limit of $3,000 a year. In addition, I establish a per admission deductible of $350 and a 6 percent coinsurance charge starting on the second day of hospitalization.

Despite similarities, however, there are fundamental differences between your restructuring approach and mine. My whole approach to the delivery of health services relies on the private sector—on patient choice and provider competition. Therefore, I believe that to the extent any restructuring occurs, the private sector should be left to compete over coverage for the remaining cost-sharing amounts.

In your proposal, restructuring does involve deductible amounts and coinsurance. But you create a government insurance plan to pick up these cost-sharing amounts. Your rationale is that the government can provide these benefits at a lower premium cost than can the private sector.

In the first place, don't assume that all seniors either need or want such coverage. With the guarantee of catastrophic protection, many seniors will be willing to accept some limited financial risk for the cost of the services they use. Second, don't

assume a government-run Medigap plan will be either efficient or responsive to beneficiaries. In my mind, that's kind of like saying, "The average cost of a car in America is $10,000. The government can build one for $8,000. Let's save consumers some money by taking over the business." Somehow, I don't think the idea would sell very well.

The same reasoning argues for keeping Medicap in the private sector. Some seniors won't want Medigap at all. Others will want plans that cover hospital deductibles but not drugs. And still others will want the Cadillac plan that pays for everything.

But perhaps most importantly, a government-run and government-mandated Medigap plan stifles the very competition we're trying to stimulate. Consider, for example, a newly established health plan—like an IPA or PPO—that wishes to gain experience in the Medicare market. It is interested in participating in the Medicare voucher, but is uncomfortable assuming the risk until it has greater experience with an elderly population. So, under present law, the health plan decides to offer a traditional Medigap policy, to pay for those cost-sharing amounts that Medicare does not pick up. It competes against Blue Cross, Bankers Life, and whatever other Medigap policies are offered in the community.

Under present law, however, it is very difficult for this health plan to reflect its efficiency in a lower premium. If the health plan gets its patients out of the hospital in ten days rather than fifteen days, there is no savings to the plan. That's because there is presently no coinsurance under Medicare until the 61st hospital day.

Likewise, the present spell-of-illness definition means that if the health plan is successful in treating a patient with one admission instead of two, it can realize no savings. Under current law, the deductible is applied only on the first admission.

Under my proposal, a hospital deductible of $350 would be applied on a per-admission basis. Furthermore, hospital coinsurance would be applied at 6 percent of the deductible amount starting on the second day. This restructuring provides our hypothetical health plan, and any other well-run price-sensitive Medigap plan, with a reward for managing patient care efficiently.

For getting the patient out in 10 days rather than 15, the health plan would save over $100 in incurred costs ($21 x 5 days). Likewise, for admitting the patient once instead of twice, the health plan would save at least $350.

These savings would be reflected in lower premiums, which in turn would attract new beneficiaries to the plan. That's exactly how a market is supposed to work. We don't see much meaningful Medigap competition precisely because present cost-sharing does not permit it.

Consider what happens under your proposal. With a government-established premium to cover restructured cost-sharing amounts, the incentive is completely taken away from the private sector to manage patient care efficiently. Under your proposal, private health plans and their physicians would have no incentive whatsoever to keep admissions and length-of-stay down. By establishing a government-wide insurance plan, you would co-opt both the patient and the marketplace.

In summary, I would encourage you to pursue restructuring, but without the government insurance plan.

Next, I want to comment briefly on your efforts to find a way to ease the financial burden on our poor elderly. I believe it is inappropriate for policy-makers to regard all of Medicare as an entitlement to be shared equally by elderly Americans.

Part A of Medicare is an entitlement, no question about that. But part B is not. Part B is an insurance program, with 25 percent of costs paid by beneficiaries in the form of a premium, and 75 percent of costs paid by taxpayers out of general revenue.

I see no reason why those senior citizens with greater income should not be paying a greater share of premium costs. It's hard for me to understand why a millionaire like Claude Pepper should be getting a monthly subsidy of 75 percent—worth over $500 a year—from American taxpayers. He's already getting a part A benefit valued at $1200 a year. Those who can afford it should be asked to pay closer to 100 percent of actual part B premium costs, and the poor elderly should be required to pay less.

My proposal would drop every beneficiary's part B premium from 25 percent of program costs to 20 percent of program costs. In 1985, part B premiums will thus drop from $16.60/mo. to $13.28/mo. In order to pay for this reduction, a modest surcharge would be applied against every Medicare beneficiary's adjusted gross income. The end result is that the poor elderly would realize a 20 percent reduction in their monthly premium, and those with very high levels of income would be asked to pay more.

There are several other items I would like to address. One is medical education. I agree with you that Medicare should not subsidize medical education programs as it currently does. We must explore alternative funding mechanisms that involve all levels of government—federal, state, and local.

Whether or not Medicare continues its subsidy of medical education, the private sector will not. The increasingly price-sensitive hosptial market will make it more and more difficult for teaching institutions to build educational costs into their daily room rates. Rather than pay a premium for teaching, many private buyers of health services are already directing their business elsewhere. Consequently, it is imperative that we find alternative funding mechanisms for medical education—it is inappropriate to expect Medicare or private health plans to carry this cost. And let me emphasize that the solution will have to be intergovernmental—financing will not rest with either the Federal government or the state government. It will rest with both.

As many of you know, I am a strong supporter of the proposal to place a limit on the tax-exempt amount an employer can contribute to an employee's health plan. I believe this proposal makes sense from a health policy standpoint as well as a tax equity standpoint. The only question I have is whether these revenues should be dedicated to the HI trust fund. In part, that's because it's very hard to judge exactly how much revenue comes from a tax cap. Since employer contributions above the cap are simply treated as taxable income, there is no way to precisely measure how much revenue is generated by a cap. Furthermore, if we are indeed successful in using a tax cap to get employees to purchase less costly coverage, revenues will fall—but by an uncertain amount. It's just very difficult to say how much revenue the tax cap generates.

The whole question of revenue sources for Medicare brings me to the final issue I'd like to address: the question of meeting the short-fall in the trust fund by raising the federal excise tax on alcoholic beverages and tobacco products.

Let me remind you that I am not here today to tell you what you should recommend to eliminate the trust fund's projected deficit. I merely want to bring your attention to the fact that such a move represents much more than a "revenue enhancing." What, in fact, you are contemplating is a fundamental shift in federal policy—both federal health care policy and intergovernmental tax policy.

In attempting to reflect two particular risk factors such as tobacco and alcohol consumption in the "price" individuals pay for government-provided health insurance, you are embarking upon a course not even the private insurance companies have come to grips with. Now, I know, it is much easier when the government can go out and levy a tax on a particular activity than when a private insurance company must figure out a way to collect differential premiums. But, to a large extent, it is the ease of taxing these two particular activities that makes my point.

The Federal government can conveniently reflect the risk of alcohol and tobacco consumption by an appropriate tax. But what about other risk factors? If we are going to go down this path, I am compelled to look for a way to levy excise taxes on automobiles to be earmarked for the Hospital Trust Fund to reflect the risk and health costs involved in operating a car; to levy a tax on sugar and salt to reflect the well-documented health risks associated with their consumption; to levy a tax on motorcycles, motor boats, bicycles; to levy a tax on coffee and tea; and I could go on and on.

So while it may appear that what we are doing here is quite straightforward, I would submit for your consideration that we are opening up an area of potential federal social control over individual behavior as yet unexplored and unknown—all in the name of better reflecting a couple of selected risk factors. I further submit that if Medicare is indeed a universal social good it should be paid for so as to spread the risks over all of the society or paid for so that *all* risks are accurately reflected. It is a compelling argument that each should "pay his fair share" of the health care costs associated with voluntary risks he incurs; but who knows what other risks nonsmokers and nondrinkers incur that make them an extraordinary burden to the system? In other words, does it make sense to let all other risks free-ride on the system if we are going to single out two? Is it fair to single out two if it is impossible or distasteful to single out the others?

Finally, I would stress the change in intergovernmental policy this proposed recommendation represents. It constitutes a significant reversal of the long-standing policy of federal deference to states in the area of excise taxation. Since the 1950s the real federal excise tax burden on alcohol and tobacco has fallen as rates remained basically unchanged. But the overall tax burden fell very little as states moved in to pick up this new "tax room." And, by the end of the 1970s, states had increased sales, income and property taxes to the limits as evidenced by the taxpay-

er resistance that set in. This left the excise taxes as major revenue sources for hard-pressed state governments.

And make no mistake about it, the states have begun to make greater use of excise taxes. For example, in the two-year period 1981–82, 20 states raised their cigarette taxes and 18 raised their alcohol taxes. All indications are that this trend will continue for the foreseeable future.

There is little doubt that any substantial federal increase in the excise taxes at this time would have a very real and detrimental effect on the revenue-raising capacity of state governments across the nation. Excise taxes have long been regarded as the province of state governments and, in my opinion, should remain so. During a period when federal aid to state and local governments is decreasing, the Federal government should be looking for ways to return revenue sources to states, not remove them.

Senator DURENBERGER. I would also indicate that the Health Subcommittee which I chair already has set a rather substantial agenda for itself during the course of 1984 to identify the problems of indigent care, which are tied very closely to changes we make in medicare. We have set ourselves a schedule to look at medical education, which this Commission points out to us is an important consideration in dealing with reform of medicare. We will be looking at catastrophic protection, and we will be looking at catastrophic in the larger sense of liver transplants, heart transplants, and some of the organ transplants that we haven't even heard of yet because medical technology hasn't refined them. We will be having hearings on bills that I have introduced to provide catastrophic coverage for medicare beneficiares, and we will have hearings on income testing, part B of medicare. We will be having hearings on maternal and child health programs. We will be having hearings on physician payment under medicare. We will have hearings on prospective payment for skilled nursing facilities and for the expansion of the prospective payment system to include all providers including physicians. And we will have hearings continually on improving the complexity and the severity for the DRG base which we are currently using.

And finally, we will look closely at the demonstrations that are taking place on vouchers. I think it is no secret to anyone here that my view is that the DRG system is a temporary system for changing the way all of us reimburse health care providers. A capitated system in the form of vouchers is a much preferable way to finance access to health care in this country, and to hold down the costs in medicare and medicaid and in other third-party payment systems. So, I join with my colleagues on this committee in welcoming our witnesses today, and I look forward to their testimony.

Senator PACKWOOD. Thank you, David. I have a statement from Senator Dole. I would ask unanimous consent that that be placed in the record just prior to my statement.

We will start this morning with a panel consisting of Roland E. King, the Director, Office of Financial and Actuarial Analysis with the Health Care Financing Administration, Department of Health and Human Services, and Hinda Ripps Chaikind, associate analyst for the Congressional Budget Office.

You may treat your statements as you want. I have had a chance to read both of them in toto, and they will be in the record as if given. You may abbreviate them or give them in full, as you wish.

STATEMENT OF ROLAND E. KING, DIRECTOR, OFFICE OF FINANCIAL AND ACTUARIAL ANALYSIS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. KING. Thank you very much, Mr. Chairman. I am pleased to be here with you today to discuss the financial status of the medicare hospital insurance trust fund.

I would like to discuss with you the results of the 1984 trustees report which was just sent from the Board of Trustees to the Congress last Thursday. But before I do that, I would like to just develop for you the rationale that the advisory council used in arriving at its assumption that the hospital insurance trust fund faced a deficit of between $200 and $300 billion by 1995. Over here on my left are the estimated operations of the hospital insurance trust fund between calendar year 1984 and 1995.

It is based on alternative 2b, which is the intermediate assumptions of the 1984 trustees report. The Advisory Council, of course, only had the 1983 trustees report, but the basic projections have changed so little that this chart is fine for illustrating the conditions that the Advisory Council is facing. As you can see, the trust fund is completely depleted in 1991 under this set of projections, and the accumulated deficit by the end of calendar year 1995 is $162.5 billion. This is accumulated with interest and it also assumes that the increase in the prospective payment rate for admission after 1985 will be the hospital input price index or the market basket plus 1 percent. The way that the advisory council arrived at their $200 to $300 billion is that the deficit is $162.5 billion, and then in order to remain financial viable, the hospital insurance trust fund needs a trust fund ratio (which is the ratio of the assets at the beginning of the year to the outgo during the year) of roughly 50 percent.

So, you can see that to that $162.5 billion, one should add roughly another, say, $75 to $80 billion to put the trust fund ratio at 50 percent of the following year's outlays. Thus the Advisory Council's decision is that they should base their deliberations on a deficit of $200 to $300 billion. On the second chart, I am going to go into the methods that we use in the trustees report to evaluate the financial status of the trust fund. Of course, it is financed basically on a pay-as-you-go basis by payroll taxes, and the trust fund only provides a small reserve to absorb fluctuations in experience. So, there are two measures of financial status. The first is the trust fund ratio, which I already defined for you, and this ratio basically measures the adequacy of the trust fund as a contingency reserve. And the second measure of status—the actuarial balance—is defined as the 25-year average of the difference between the tax rate and the program cost, where the cost has been expressed as a percent of the taxable payroll. And this is really a measure of the long-term adequacy of the financing of the program, as opposed to the short-term measure of the adequacy of the trust fund reserve. The third chart shows both historical and projected trust fund ratios for the hospital insurance trust fund. As you can see, the trust fund ratios have declined basically every year since 1977. It took a precipitous drop at the end of 1982 when the $12.4 billion

loan to the OASI trust fund was made, and it is projected to pick up somewhat between now and 1988 as the loan to the OASI trust fund is repaid, and as the tax rate increases which are already scheduled in law come into effect, and then it is projected to decrease rather rapidly from its peak in 1988 to 1991 when the trust fund is completely depleted.

Those are the short-term measures of the financial status. The long-term measure is the actuarial balance of the hospital insurance program. I haven't shown all the years on this chart, but it shows for selected years over the 25-year projection period between 1984 and 2008 the tax rate that is scheduled in current law and the program costs expressed as a percent of taxable payroll. And then the actuarial balance, minus 1.37 percent, is just the difference between the tax rate scheduled in the law and the program costs. The trust fund would be said to be in close actuarial balance if the difference was close to zero, and it would be said to be in a surplus position if the difference was greater than zero. The next chart simply shows on a figurative basis the figures that I showed you on the previous chart, and as you can see, the difference between the projections of the cost of the program as a percent of taxable payroll and the HI tax rates historically has been quite close. There have been areas where there has been a surplus, and areas where there has been an offsetting deficit, but basically they have tracked very well.

And then you can see that in the future the HI tax rates just aren't adequate to support the costs of the program if these assumptions are realized. Once again, these projections are based on the alternative 2b assumptions. So, the basic conclusions of the 1984 trustees' report are first that the trust fund ratio is significantly below the 50-percent minimum adopted by the Board of Trustees. The trust fund will be depleted by 1991, and a cautionary note—because of the low reserve levels in the trust fund, even a temporary deviation of the actual experience from the projections could result in depletion before 1991. And the final conclusion is that, in order to achieve close actuarial balance over the 25-year projection period, either income must be increased by 48 percent, or outlays must be reduced by 32 percent over the next 25 years. I would like to discuss the importance of the trust fund reserve. It is important of course, to absorb temporary fluctuations in experience. It is important to build a reserve to prepare for the demographic shift which occurs after the turn of the century, that is, when all of the post-World War II baby boom begins to retire and become eligible for hospital insurance benefits.

It is necessary if the long-term projections prove to be inaccurate. It allows Congress time to take corrective action while preserving equity among different generations of beneficiaries, and it allows Congress time to make changes in the program without disrupting the financial planning of those currently retired or near retirement.

And it also allows, as you can see from the previous chart, tax rate schedules with rate changes that occur at intervals of several years instead of going up every year as the cost of the program increases. The final chart simply shows the projected year of deletion in the HI trust fund in trustees' reports going back to 1975, which

is the first year when an actual year of depletion of the trust fund was projected. However, in years before 1975, the trustees' report conclusions suggested that if policy actions were not taken in order to bring the cost of hospital benefits under control that the projections could prove to be inaccurate. That concludes my testimony, Senator, and if there are any questions, I would be happy to answer them.

[The prepared written statement of Mr. King and answers to questions from Senator Dole follow:]

STATEMENT OF GUY KING, DIRECTOR, OFFICE OF FINANCIAL AND ACTUARIAL ANALYSIS, HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN, I AM GUY KING, CHIEF ACTUARY FOR THE HEALTH CARE FINANCING ADMINISTRATION (HCFA). I AM PLEASED TO BE HERE TODAY TO DISCUSS WITH YOU THE FINANCIAL STATUS OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND.

AS THE SENATE FINANCE COMMITTEE BEGINS ITS CONSIDERATION OF THE RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY, IT WOULD BE USEFUL FOR THE MEMBERS TO UNDERSTAND THE MAGNITUDE OF THE FINANCIAL DEFICIT IN THE HOSPITAL INSURANCE (HI) PROGRAM WHICH WAS ACKNOWLEDGED BY THE COUNCIL IN ARRIVING AT ITS RECOMMENDATIONS.

THE FIRST TABLE SHOWS THE PROJECTED OPERATIONS OF THE HI TRUST FUND THROUGH 1995. OF COURSE, THE FIGURES FOR 1991 AND LATER ARE THEORETICAL, SINCE THE FUND IS PROJECTED TO BE COMPLETELY DEPLETED BY 1991. THIS CHART SHOWS THAT THE TRUST FUND, UNDER CURRENT LAW, WILL HAVE ACCUMULATED A NEGATIVE BALANCE OF OVER $160 BILLION BY 1995. SINCE THE TRUST FUND MUST RETAIN A BALANCE OF 50 PERCENT OF OUTLAYS IN ORDER TO REMAIN FINANCIALLY VIABLE, THE ACCUMULATED DEFICIT THROUGH 1995 WILL BE IN EXCESS OF $200 BILLION. THE ADVISORY COUNCIL ADOPTED AS ONE OF ITS GOALS THE PRESERVATION OF A FINANCIALLY VIABLE HI TRUST FUND AT LEAST THROUGH 1995. HENCE, THE ADVISORY COUNCIL ADOPTED THE POSITION THAT THE ACCUMULATED HI DEFICIT WHICH HAD TO BE ADDRESSED WAS $200-$300 BILLION THROUGH 1995.

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IT SHOULD BE NOTED THAT THE PROJECTIONS SHOWN HERE ARE BASED ON THE ASSUMPTION THAT THE INCREASE IN PAYMENTS TO HOSPITALS IN 1986 AND LATER WILL BE EQUAL TO THE INCREASE IN THE HOSPITAL INPUT PRICE INDEX (MARKET BASKET) PLUS ONE PERCENT. SINCE THE ACTUAL INCREASE IN THE PAYMENT RATES IS AT THE DISCRETION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES, THE VALIDITY OF THESE PROJECTIONS IS HIGHLY DEPENDENT UPON HOW THE SECRETARY EXERCISES THAT DISCRETION IN THE FUTURE. IT SHOULD ALSO BE NOTED THAT THESE FIGURES ASSUME THAT THE $12.4 BILLION LOAN TO THE OLD AGE SURVIVORS INSURANCE (OASI) TRUST FUND WILL BE COMPLETELY REPAID BY 1987.

AS YOU KNOW, THE HI PROGRAM IS FINANCED ON A PAY-AS-YOU-GO BASIS. THAT IS, THERE IS NO SUBSTANTIAL FUND ACCUMULATED TO GUARANTEE THE PAYMENT OF FUTURE BENEFITS. THUS, ONLY A SMALL TRUST FUND IS ACCUMULATED TO SERVE AS A CONTINGENCY RESERVE. WITH THIS FORM OF FINANCING, THERE ARE TWO BASIC INDICATORS OF THE FINANCIAL STATUS OF THE PROGRAM -- A SHORT-RANGE MEASURE CALLED THE "TRUST FUND RATIO" AND A LONG-RANGE MEASURE CALLED THE "ACTUARIAL BALANCE". THE TRUST FUND RATIO IS DEFINED AS THE RATIO OF THE BALANCE IN THE FUND AT THE BEGINNING OF THE YEAR TO OUTLAYS DURING THE YEAR. THE TRUST FUND RATIO INDICATES THE ADEQUACY

OF THE TRUST FUND AS A CONTINGENCY RESERVE. THE LONG-RANGE INDICATOR, THE ACTUARIAL BALANCE, IS DEFINED AS THE 25-YEAR AVERAGE OF THE DIFFERENCE BETWEEN TAX RATES AND PROGRAM COSTS, WHERE THE PROGRAM COSTS ARE EXPRESSED AS A PERCENT OF THE TAXABLE PAYROLL -- THE PAYROLL UPON WHICH THE FEDERAL INCOME CONTRIBUTIONS ACT (FICA) TAXES ARE LEVIED. THE ACTUARIAL BALANCE INDICATES THE ADEQUACY OF THE FINANCING OF THE PROGRAM. IF THE ACTUARIAL BALANCE IS POSITIVE, A FINANCING SURPLUS EXISTS; IF IT IS NEGATIVE, A DEFICIT EXISTS; IF IT IS ZERO, THEN THE PROGRAM IS SAID TO BE IN ACTUARIAL BALANCE. ACCORDING TO BOTH INDICATORS FOR FINANCIAL STATUS, THE HI PROGRAM IS INADEQUATELY FINANCED, AND THE RESERVES OF THE PROGRAM ARE INADEQUATE TO MAINTAIN FINANCIAL VIABILITY.

FIRST, LET'S EXAMINE THE TRUST FUND RATIOS. THE 1971 SOCIAL SECURITY ADVISORY COUNCIL RECOMMENDED THAT THE HI TRUST FUND RATIOS BE MAINTAINED AT 100 PERCENT. THE BOARD OF TRUSTEES SUBSEQUENTLY ADOPTED THAT SAME STANDARD. HOWEVER, IN 1981, THE BOARD LOWERED THE STANDARD TO 50 PERCENT. AS YOU CAN SEE, THE TRUST FUND RATIO HAS GENERALLY DECLINED SINCE 1977; IT TOOK A PRECIPITOUS DROP IN 1982 WHEN THE $12.4 BILLION LOAN TO THE OASI TRUST FUND WAS MADE; AND

IT IS PROJECTED TO REMAIN ABOVE 20 PERCENT UNTIL THE LATE 1980'S, WHEN IT WILL DECLINE RAPIDLY UNTIL COMPLETELY EXHAUSTED IN 1991.

THE 25-YEAR ACTUARIAL BALANCE OF THE HI PROGRAM IS COMPUTED BY SUBTRACTING THE ESTIMATED AVERAGE COST OF THE PROGRAM OVER THE 25-YEAR PERIOD FROM 1984 TO 2008 (WHICH IS 4.25 PERCENT) FROM THE AVERAGE TAX RATE DURING THAT SAME PERIOD (WHICH IS 2.88 PERCENT). THUS, THERE IS A LONG-RANGE ACTUARIAL DEFICIT OF 1.37 PERCENT. THE NEXT GRAPH COMPARES THE COST OF THE PROGRAM, EXPRESSED AS A PERCENT OF TAXABLE PAYROLL, WITH THE TAX RATES CURRENTLY SCHEDULED IN THE LAW. THE AREA IN BETWEEN THE PROJECTED COSTS AND THE TAX RATES IS THE DEFICIT. THE LARGE GAP IN THIS AREA CLEARLY ILLUSTRATES THE INADEQUACY OF THE CURRENT FINANCING SCHEDULE FOR THE HI PROGRAM.

THE FINANCIAL STATUS OF THE HI TRUST FUND CAN BE SUMMARIZED AS FOLLOWS:

1. THE TRUST FUND RATIO IS SUBSTANTIALLY BELOW THE 50 PERCENT MINIMUM LEVEL ADOPTED BY THE BOARD OF TRUSTEES.

2. UNDER CURRENT LAW, OUR PROJECTIONS SHOW THAT THE TRUST FUND WILL BE DEPLETED IN THE LATE 1980'S OR EARLY 1990'S.

3. Because of the low reserve levels in the Trust Fund, even a temporary deviation from the projections could result in depletion much earlier than currently projected.

4. To bring the Trust Fund into actuarial balance, either income must be increased by 48 percent or outlays must be reduced by 32 percent over the next 25 years.

I would like to emphasize the importance of maintaining a balance in the HI Trust Fund of a minimum of 50 percent of outlays. The reserve in the Trust Fund serves several important functions:

1. It absorbs temporary fluctuations in experience, such as those resulting from the business cycle.

2. It allows the accumulation of a reserve to accommodate the demographic shift which occurs after the turn of the century.

3. If the long-term projections prove to be inaccurate, it allows time for corrective action to be taken without making disruptive changes in the program while preserving equity among different generations of taxpayers and beneficiaries.

4. IT ALLOWS TAX RATE CHANGES TO OCCUR AT INTERVALS OF SEVERAL YEARS RATHER THAN ANNUALLY AS PROGRAM COSTS INCREASE.

FINALLY, THERE MAY BE DOUBTS IN YOUR MINDS WHETHER THE PROJECTIONS WHICH I HAVE DISCUSSED WILL PROVE TO BE ACCURATE. THIS LAST CHART IDENTIFIES THE PROJECTED YEAR OF DEPLETION FROM PREVIOUS TRUSTEES' REPORTS DATING BACK TO 1975. SO FAR, ACTUAL EXPERIENCE TRACKS FAIRLY WELL WITH OUR EARLIER PROJECTIONS.

ALTHOUGH 1975 WAS THE FIRST YEAR IN WHICH A SPECIFIC DATE OF DEPLETION WAS MENTIONED IN A REPORT, TRUSTEES' REPORTS ISSUED PRIOR TO THAT YEAR INCLUDED THE WARNING THAT THE LONG-RANGE PROJECTIONS WOULD PROVE TO BE OVERLY OPTIMISTIC UNLESS PUBLIC POLICY PRESSURES WERE BROUGHT TO BEAR TO REDUCE THE RATE OF INFLATION IN HOSPITAL COSTS.

THANK YOU FOR THE OPPORTUNITY TO PRESENT THESE VIEWS TO YOU. I WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

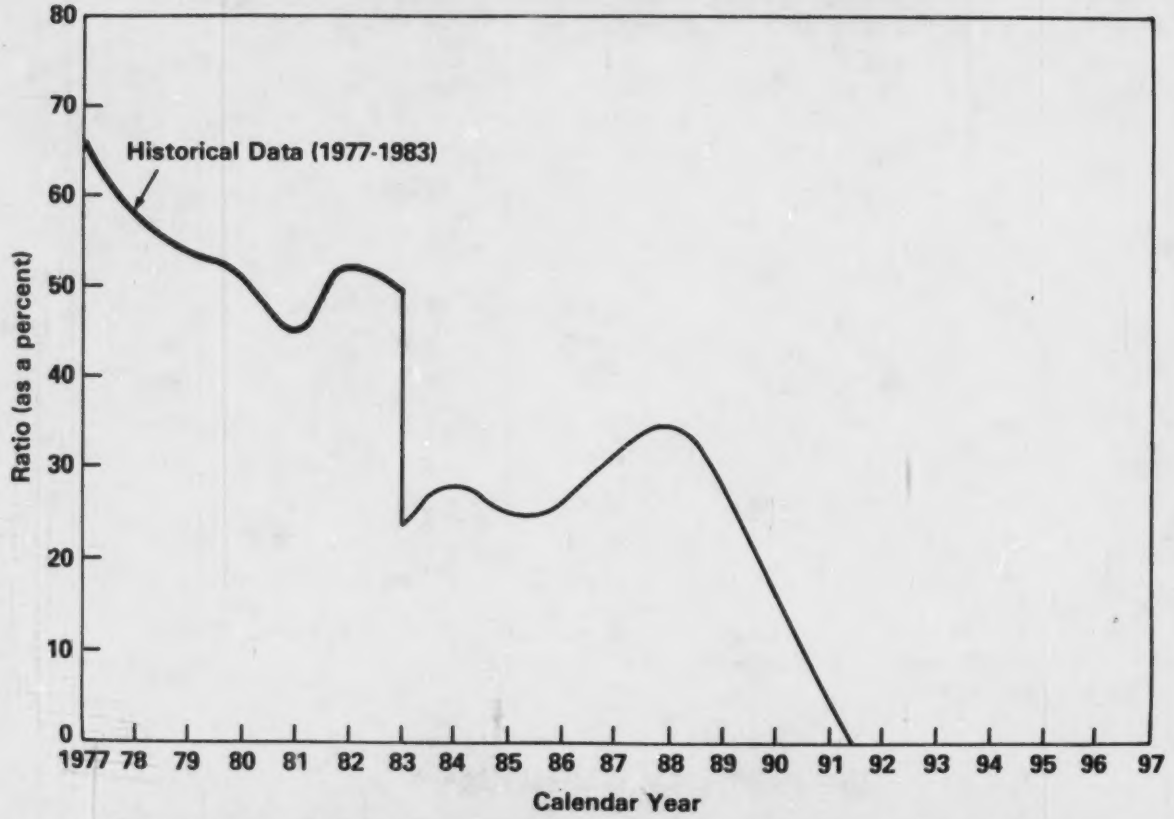
Estimated Operations of the HI Trust Fund (Amounts in Billions)

Calendar Year	Income	Outgo	Net Increase in Fund	Fund at End of Year	Assets at Beginning of Year As a Percentage of Outgo During Year
1984	$46.3	$46.1	$ 0.2	$ 13.1	28%
1985	52.5	52.7	-0.2	12.9	25
1986	65.8	58.7	7.1	20.0	22
1987	72.0	65.5	6.6	26.6	31
1988	69.6	73.1	-3.5	23.1	36
1989	73.7	81.1	-7.4	15.7	28
1990	77.6	89.8	-12.2	3.5	17
1991	81.2	99.4	-18.2	-14.7	4
1992	84.7	109.2	-24.5	-39.2	-13
1993	88.1	120.2	-32.0	-71.2	-33
1994	91.4	132.2	-40.8	-112.0	-54
1995	94.7	145.1	-50.5	-162.5	-77

Note:

1. The Income Figures for 1986 and 1987 Reflect Scheduled Loan Repayments From the OASI Trust Fund of $5.5 and $6.9 Billion, Respectively.
2. The HI Trust Fund Operations for 1991 and Later Are Theoretical, Since the Fund Would Be Depleted in 1991 Under This Set of Assumptions.

Short Term HI Trust Fund Ratios



Note: The trust fund ratio is defined as the ratio of assets in the trust fund at the beginning of the year to

Actuarial Balance of Hospital Insurance Program

Year	Tax Rate in Law	Program Costs[1]	Taxes Minus Cost
1984	2.6%	2.79%	-0.19%
1985	2.7	2.92	-0.22
1990	2.9	3.57	-0.67
1995	2.9	4.20	-1.30
2000	2.9	4.75	-1.85
2005	2.9	5.23	-2.33
25-Year Average	2.88%	4.25%	-1.37%

The Average Difference for the 25-Year Period From 1984 to 2008 Between Taxes and Cost, -1.37%, Is Called the "Actuarial Balance."

[1] Program Costs Expressed As a Percent of Taxable Payroll, Including an Allowance to Maintain the Trust Fund at the Level of One-Half Year's Expenditures.

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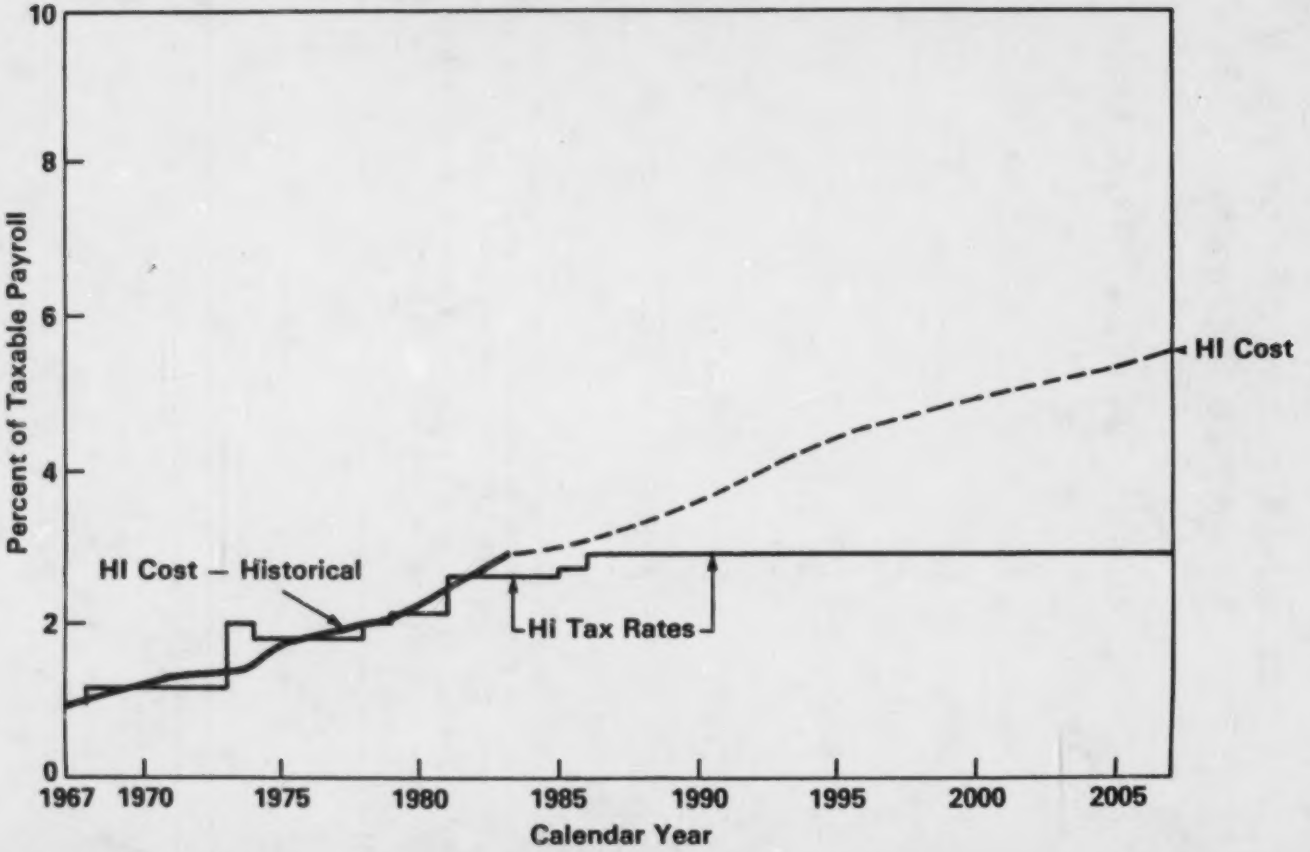
Estimated HI Cost and Tax Rates



Summary
Financial Status of Hospital Insurance Trust Fund

- Trust Fund Ratio at Beginning of CY 1984 Is Substantially Below the 50% Minimum Adopted by the Board of Trustees
- Trust Fund Will Be Depleted by 1991
- Because of Low Reserve Levels, Even a Temporary Deviation From Projections Could Result in Depletion Before 1991
- To Achieve Close Actuarial Balance, Income Must Be Increased by 48% or Outlays Reduced by 32% Over the Next 25 Years

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

MAY 15 1984

The Honorable Robert J. Dole
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your letter regarding my testimony on the financial status of the Hospital Insurance Trust Fund before the Senate Finance Committee on April 9, 1984.

You included in your letter several questions you would like to have answered for the hearing record. I have enclosed my responses to those questions.

Thank you for the opportunity to participate in this important hearing.

Sincerely,

Roland E. King

Roland E. King
Director
Office of Financial and
Actuarial Analysis

Enclosure

Questions for Mr. King from Testimony Given April 9, 1984

1. The Board of Trustees recommends that Congress consider further action to curtail the rapid growth in the cost of the Hospital Insurance (HI) program. That growth can be broken down into three components:

   A. Increases due to changes in the price of labor, goods and services;

   B. Increases due to changes in the quantity and mix of services per patient; and

   C. Increases due to changes in the volume of patients treated.

   Which and to what extent do the trustees believe any of these components should be modified to curtail cost growth?

   I can't speak for the trustees. However, I believe that in order to effect reductions in the growth in the HI program of the magnitude needed to bring the program into actuarial balance, all three components of growth will have to be curtailed.

2. To what extent have you incorporated changes in hospital admission rates in response to the DRG system in your projections? For example, your table A1 shows annual increases in admissions per enrollee of approximately 2.0 percent through 1986 while last year you estimated increases of only about 1.1 percent per year - what accounts for this difference?

   As you can see by examining the historical increases in table A1, increases in admission incidence fluctuate widely and unpredictably from year to year. The revision in the admission incidence rate in the early years of the projection is small relative to historical fluctuations. It reflects recent trends in admission incidence rates rather than a judgment that admission incidence will increase under prospective payment.

3. To what extent are your estimates of outlay savings from restructuring the HI program as recommended by the Council due to reduced utilization among persons who would refuse to buy the optional Part A benefit package?

   The outlay savings from restructuring the HI program are the result of increasing the HI deductible and coinsurance, not of reduced utilization. Since the Part A benefit package is mandatory for those who wish to enroll for Supplementary Medical Insurance (SMI) coverage, it is likely that virtually all of those who currently enroll in the SMI program would select the combined Part B/Part A package. The current law Part B premium is a very attractive investment. The combined Part B/Part A package is a similarly attractive investment, since it eliminates the need for "Medigap" policies for Part A services.

4. You have again underscored the trustees' recommendation of a 50 percent reserve ratio for the HI trust fund. Given the accuracy of your estimates in recent years, why is this necessary? How does this compare with the reserve ratios required in the OASDI programs?

I would like to emphasize that the 50 percent trust fund ratio is a minimum. The fund should not only provide a contingency reserve, it should be used to eliminate or ameliorate inequities among different generations of beneficiaries. Because of the demographic shift which occurs after the turn of the century, the trust fund should actually build to a level considerably greater than 50 percent. The OASI trust fund, for example, builds to a level of 580 percent by the year 2015 under the intermediate alternative II-B assumptions. The HI trust fund ratio should build to a similar level in order to preserve the equity of the program.

5. To what extent would it be feasible to impose income related cost-sharing mechanisms under Part A? For example, a sliding-scale deductible or copayment amount for hospital inpatient care.

I have not had operational experience with administering cost sharing mechanisms for health programs. I would have to defer the answer to that question to the people who administer the HI program.

Senator PACKWOOD. I think, if you don't mind, we will take Ms. Chaikind first.

Mr. KING. That is perfectly all right.

STATEMENT OF HINDA RIPP[illegible]HAIKIND, ASSOCIATE ANALYST, CONGRESSIONAL BUD[illegible]F OFFICE, WASHINGTON, DC

Ms. CHAIKIND. Mr. Chairman, I am pleased to appear before the committee today to discuss CBO's recent projection of outlays, income, and balances in the hospital insurance trust fund. While our current law projections show annual income exceeding annual outlays for the next 4 years, we expect a reversal in this relationship after 1988. In the absence of a change in current laws, we anticipate balances in the hospital insurance trust fund falling to zero sometime between fiscal years 1992 and 1994, although the exact timing depends on the behavior of the economy, the rates of increase in medicare hospital reimbursement, and other special factors influencing hospital costs. The trust fund could be depleted by 1991 or perhaps not until 1995 or even later. Sound financial management, of course, requires maintenance of some reserves to allow for unexpected variations in outlays or revenues. This implies that the critical period will arrive before the depletion of the fund—almost certainly in the 1990's. My testimony today will deal with baseline projections of medicare's hospital insurance trust fund from 1984 to 1995, and the sensitivity of these projections to alternative economic scenarios and to change in the growth of hospital expenditures.

The hospital insurance [HI] portion of medicare covers hospitals, home health, and skilled nursing care for 30 million aged and disabled persons. CBO estimates that the Federal Government will spend $44 billion on this in fiscal year 1984, and will receive $46 billion in income.

Outlays are projected to grow at an annualized rate of 11.5 percent and income to the trust fund at a 7.5-percent yearly rate, on average from 1984 to 1995. Under CBO's baseline assumptions, outlays are projected to approach $150 billion by 1995. Because revenues are estimated to grow more rapidly in the beginning of the projection period than at the end, the trust fund balance is expected to increase through 1988 and start to decline by 1989. By 1995 the deficit could approach $100 billion. For those of you who have a copy of my testimony, you can see on page 3, table 1 shows the figures of our baseline budget projections.

TABLE 1.—BASELINE BUDGET PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES

[By fiscal year, in billions of dollars]

Years	Total outlays	Income	Year-end balance
1984	44	46	15
1985	50	52	17
1986	55	61	24
1987	61	73	35
1988	68	73	40
1989	76	75	38
1990	85	79	33
1991	95	84	22
1992	106	89	5
1993	118	94	−19
1994	132	98	−53
1995	147	102	−97

Source: CBO estimates.

The projected annual growth in spending of 11.5 percent comprises projected increases in hospital costs, enrollment, utilization, and other factors. The basic cost of providing hospital care is measured by a market basket of goods and services. This market basket is a weighted average of the costs of labor, capital goods, and supplies. Labor costs account for almost two-thirds of the total market basket. Under CBO's baseline economic assumption, the total market basket for hospital costs is projected to increase by about 6 percent annually.

The market basket is a key component in determining medicare hospital reimbursement. Recent legislation has changed hospital reimbursement from a cost base system to a prospective payment system based on Diagnosis Related Groups [DRG's]. Under existing law, the DRG rates are said to be budget-neutral through 1985. That is, they should have no cost or savings impact on medicare hospital reimbursement. After 1985 the Secretary of Health and Human Services will determine increases in the DRG rates. For this reason, CBO has followed the conventions used by the HI actuary to project increases beyond 1985 and assumed growth rates equal to the market basket rate plus 1 percent. The 1 percent is designed to allow for improvements in medical technology. In addition, CBO has added to its projections another 1.5 percent per year to allow for growth in medicare hospital reimbursement not specifically limited by the Secretary. This growth, for example, could be the result of changes in admitting practices of hospitals or in-

creases in medical technology that had the effect of increasing admissions. The remaining 3-percent annual increase in HI outlay growth—bringing total increases to 11.5 percent a year—stems from projected increases in both enrollment and hospital admission rates.

The components of the annual growth in outlays can be summarized as follows:

	Percent
Market basket plus one	7.0
Caseload	3.0
Other growth	1.5
Total	11.5

On the income side, revenues flow into the trust through payroll taxes and through general revenue transfers. Revenues depend on wages and salaries and employment. Increases in wages and salaries determine the per person increases in revenues to the trust fund. The level of employment determines the pool of individuals to be taxed. The 7.5 percent average annual growth in revenues is best explained in two time frames—pre- and post-1988. Between 1984 and 1988 a very special set of circumstances will increase income to the HI trust fund. First, the Old Age and Survivors Insurance [OASI] trust fund is expected to repay the HI trust fund with a loan of $12.4 billion. Second, the HI payroll tax is scheduled to increase from 1.3 percent to 1.35 percent in 1985 and to 1.45 percent in 1986, overall a 12-percent increase. No tax increases are scheduled after 1986.

Thus, while spending is projected to maintain increases of over 11 percent a year, revenue growth is expected to keep pace only through 1988. After 1988 when the loan to the OASI trust fund is fully repaid and all scheduled HI payroll taxes are in place, the trust fund balance is projected to begin to decline.

The timing of the potential HI trust fund problem is highly uncertain for several reasons. The uncertainty of the underlying economic assumptions, the unknown rates of increase in DRG prices after fiscal year 1985, and the effect of the DRG system on the use of hospitals, on other health care providers, and on the growth in medical technology. I will briefly discuss the implications of these uncertainties for the HI trust fund projections.

Projections of HI trust fund balances are sensitive to the relationship between the growth in wages and inflation—that is, to real wage growth.

CBO's projection of the hospital insurance trust fund under alternative economic scenarios. Again, for those of you with a copy of my testimony, that will be on page 9. Both spending and income vary with the economic assumptions. Projections of the trust fund balances are less sensitive to economic assumptions, as the projections of wages and salaries play a role in projecting revenues and spending.

Under baseline forecasts, the trust fund could be depleted in 1993. Under the high growth path, the trust fund could meet its obligations for about 1 additional year. Spending is higher under the high-growth path largely because prices and wages are assumed to grow at a higher rate. Revenues, however, are much

higher, because of the higher inflation and wages, and the lower unemployment rates. Under this high-growth path, spending is estimated to increase at an average annual rate of about 13.5 percent from 1984 to 1995, while revenues are projected to increase at about 10.5 percent annually.

The low-growth economic assumptions represent a slightly more pessimistic scenario in which the trust funds could be depleted in 1992. This economic scenario results in approximate yearly spending increases of 9.5 percent and revenue increases of 4.5 percent.

While these differences in economic assumptions cover some of the uncertainty in the trust fund projections, they do not account for all of it. I will turn now to some of the other important factors that could determine the growth in spending for the HI trust fund.

As you know, beginning in October 1983, hospital reimbursement under medicare underwent a major change from a cost-based system to a system of prospective payments based on DRGs. This system was designed for gradual implementation and is expected to be fully in place by 1986. After 1985 the Secretary, with the advice of a special commission, will set increases in the DRG rates. Because these have not yet been determined, projections of HI spending are made more uncertain.

Another important factor in the estimates is the potential effect of the DRG system on utilization and admitting practices of hospitals. For example, hospitals could switch certain diagnoses from outpatient to inpatient care in an effort to maximize medicare reimbursement. Estimating this effect is problematic because the system has only been in use since October 1983. Thus, while DRG's could change hospital's future utilization admitting patterns, as well as making other adjustments that are important in determining the cost of medicare hospital care, it is still too early to determine the impact.

If the DRG's have a larger or smaller impact on the costs and utilization of the program than is assumed in the CBO baseline, spending could be higher or lower than projected. Additionally, advances in medical technology could result in either more or less admissions depending on the nature of the technological change. Table 3 shows the CBO baseline projections modified by a one percentage point increase or decrease in the rate of change in medicare hospital reimbursement. These modifications could be the result of changes in admissions, in utilization, or in the rate of increase for DRG's set by the Secretary of Health and Human Services. For example, if the growth rate in medicare hospital reimbursement is 1 percentage point lower than assumed in the baseline, spending will be $0.4 billion less for the first year. The amount increases greatly every year, so that by 1995 the difference could total $57 billion. In addition, these outlay savings would result in more interest earned on the trust fund. As a result, the trust fund could be able to meet its obligations until 1994. Conversely, if the increase in hospital reimbursement was one percentage point higher than assumed in baseline, the trust fund could be depleted in 1991.

CBO also examined an even more optimistic and an even more pessimistic projection for the trust fund. Combining the high-growth economic path with a one percentage point lower increase

in other hospital costs results in a very optimistic scenario. The pessimistic scenario combines the low-growth economic path with a one percentage point higher increase in other hospital costs. These projections are shown in table 4. Under the best-case scenario, the trust funds are solvent throughout the projection period, although the end-of-year balances decline over the later part of the period indicating that the fund will eventually be depleted. Under the worst-case scenario, the trust fund is depleted in 1991.

Finally, another significant component to be considered in estimating spending is recent trends. Since August 1983, spending in HI has been much lower than anticipated. For the first 4 months of fiscal year 1984, relative to the same period for 1983, outlays—adjusted for the temporary delay in periodic interim payments—increased by only 7.5 percent. This decline in the rate of growth could not be due solely to the direct impact of DRG's, because they are too new to hold down the growth so significantly. If this new trend is sustained, the outlook for the trust funds could be very different from that projected.

The alternatives I have discussed demonstrated that the projections of HI spending are sensitive to many factors. As the DRG system is fully implemented, some of this uncertainty should dissipate. One factor, however, remains constant in these projections. Under current law, growth in spending is projected to outpace the growth in revenues so that the trust fund is likely to be either in critical condition or depleted in the early 1990's. This is the issue that must be addressed by the Congress in the future.

This concludes my statement, Mr. Chairman. I will be pleased to respond to any questions you or other members of the Committee may have.

[The prepared written statement of Ms. Chaikind and answers to questions from Senator Dole follow:]

STATEMENT OF HINDA RIPPS CHAIKIND, ASSOCIATE ANALYST, CONGRESSIONAL BUDGET OFFICE

Mr. Chairman, I am pleased to appear before the Committee today to discuss CBO's recent projections of outlays, income, and balances in the Hospital Insurance trust fund. While ours current law projections show annual income exceeding annual outlays for the next fours years, we expect a reversal in this relationship after 1988. In the absence of a change in current laws, we anticipate balances in Hospital Insurance trust fund falling to zero some time between fiscal years 1992 and 1994, although the exact timing depends on the behavior of the economy, the rates of increase in Medicare hospital reimbursement, and other special factors influencing hospital costs. The trust fund could conceivably be depleted by 1991, or perhaps not until 1995 or even later. Sound financial management, of course, requires maintenance of some reserves to allow for unexpected variation in outlays or revenues. This implies that the critical period will arrive before depletion of the fund—almost certainly in the early 1990s.

My testimony today will deal with:

Baseline projections of Medicare's Hospital Insurance trust fund from 1984 to 1995.

The sensitivity of these projections to alternative economic scenarios and to changes in the growth of hospital expenditures.

CBO BASELINE ESTIMATES

The Hospital Insurance (HI) portion of Medicare covers hospital, home health, and skilled nursing care for 30 million aged and disabled persons. CBO estimates that the federal government will spend $44 billion on this in fiscal year 1984 and will receive $46 billion in income. Outlays are projected to grow at an annualized

rate of 11.5 percent, and income to the trust fund at a 7.5 percent yearly rate on average from 1984 to 1995. Under CBO's baseline assumptions, outlays are projected to approach $150 billion by 1995. Because revenues are estimated to grow more rapidly in the beginning of the projection period than at the end, the trust fund balance is expected to increase through 1988 and start to decline in 1989. By 1995 the deficit could approach $100 billion. These figures are shown in Table 1.

The projected annual growth in spending of 11.5 percent comprises projected increases in hospital costs, enrollment, utilization, and other factors. The basic cost of providing hospital care is measured by a market basket of goods and services. This market basket is a weighted average of the costs of labor, capital goods, and supplies. Labor costs, accounting for almost two-thirds of the total market basket, are assumed to grow at an average rate of more than 6 percent per year. The costs of capital goods and supplies are assumed to grow at the same rate as the projected growth in consumer prices. Under CBO's baseline economic assumptions, the total market basket for hospital costs is projected to increase by about 6 percent annually.

TABLE 1.—BASELINE BUDGET PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES

[By fiscal year, in billions of dollars]

Years	Total outlays	Income	Year-end balance
1984	44	46	15
1985	50	52	17
1986	55	61	24
1987	61	73	35
1988	68	73	40
1989	76	75	38
1990	85	79	33
1991	95	84	22
1992	106	89	5
1993	118	94	−19
1994	132	98	−53
1995	147	102	−97

Source: CBO estimates.

The market basket is a key component in determining Medicare hospital reimbursement. Recent legislation has changed hospital reimbursement from a cost-based system to a prospective payment system based on Diagnosis Related Groups (DRGs). Under existing law, the DRG rates are set to be budget-neutral through 1985, meaning that they should have no cost or savings impact on Medicare hospital reimbursement. After 1985, the Secretary of Health and Human Services will determine increases in the DRG rates. For this reason, CBO has followed the convention used by HI actuaries to project increases beyond 1985 and assumed a growth rate equal to the market basket rate plus 1 percent. The 1 percent is designed to allow for improvements in medical technology.

In addition, CBO has added to its projections another 1.5 percent per year to allow for growth in Medicare hospital reimbursement not specifically limited by the Secretary. This growth, for example, could be the result of changes in admitting practices of hospitals or increases in medical technology that had the effect of increasing admissions. The remaining 3 percent annual increase in HI outlay growth—bringing total increases to 11.5 percent—stems from projected increases in both enrollment and hospital admissions rates. The components of the annual growth in outlays are summarized below.

	Percent
Market basket plus one	7.0
Caseload	3.0
Other growth	1.5
Total	11.5

On the income side, revenues flow into the trust fund through payroll taxes and through general revenue transfers. Revenues depend on wages and salaries, and employment. Increases in wages and salaries determine the per person increases in

revenues to the trust fund. The level of employment determines the pool of individuals to be taxed. The 7.5 percent average annual growth in revenues is best explained in two timeframes—pre- and post-1988. Between 1984 and 1988, a very special set of circumstances will increase income to the HI trust fund. First, the Old Age and Survivors Insurance (OASI) trust fund is expected to repay the HI trust fund a loan of $12.4 billion. Baseline projections assume a repayment schedule of $2 billion in 1986, $8 billion in 1987, and the remaining $2.4 billion in 1988. Second, the HI payroll tax rate is scheduled to increase from 1.3 percent to 1.35 percent in 1985 and to 1.45 percent in 1986, overall a 12 percent increase. No tax increases are scheduled after 1986.

Thus, while spending is projected to maintain increases of over 11 percent a year, revenue growth is expected to keep pace only through 1988. After 1988, when the loan to the OASI trust fund is fully repaid and all scheduled HI payroll tax increases are in place, the trust fund balance is projected to begin to decline.

SENSITIVITY OF THE ESTIMATES

The timing of the potential HI trust fund problem is highly uncertain for several reasons: the uncertainty in the underlying economic assumptions; the unknown rates of increase in DRG prices after fiscal year 1985 (to be set by the Secretary of Health and Human Services); and the effect of the DRG system on the use of hospitals, on other health care providers, and on the growth in medical technology. I will briefly discuss the implications of these uncertainties for the HI trust fund projections.

SENSITIVITY TO ECONOMIC ASSUMPTIONS

Projections of HI trust fund balances are sensitive to the relationship between the growth in wages and inflation—that is, to real wage growth. The real wage growth calculation is tied to productivity change by assuming that compensation rates grow at the projected rate of inflation plus some proportion of the productivity gains.

The HI baseline projections begin with the CBO economic forecast for fiscal years 1984 and 1985. Under this forecast, real GNP is projected to rise 4.7 percent over the four quarters of 1984 and 3.7 percent during 1985. The civilian unemployment rate is projected to decline from 8.5 percent in the last quarter of 1983 to 7.1 percent by late 1985.

In addition to its forecast for 1984–1985, CBO has made economic projections for 1986–1989. These projections assume moderate noncyclical growth in real GNP based on historical averages. This rate of growth is not a forecast but is based on trend growth, representing average postwar economic performance over a seven-year horizon.[1] After 1989, the baseline economic projections assume that productivity grows at annual rates averaging 2.1 percent for the 13-year period from the fourth quarter of 1982—the trough quarter of the recent recession—to the fourth quarter of 1995. This is approximately equal to the average of the growth rates experienced for the 13-year periods following cyclical troughs at the beginning of the 1950s, 1960s and 1970s.

CBO has developed two alternative economic scenarios representing high and low levels of productivity growth based on historical experience, in addition to our baseline projection. The high-growth path results in a more optimistic projection for the trust fund, while the low-growth path is more pessimistic.

For 1984–1989 the high-growth path assumes real growth similar to that of the early 1960s, averaging about 5.0 percent annually over the projection period. The unemployment rate falls to 5.3 percent by the end of the projection period, compared to 6.5 percent in the baseline. From 1989 through 1995, the high-growth path assumes productivity growth averaging 2.6 percent annually over the 13-year period from the fourth quarter of 1982 to the fourth quarter of 1995. This is similar to the high-productivity growth rates experienced during the 1950s and early 1960s. For 1984–1989, the low-growth alternative is similar to the experience of the 1970s, with real growth averaging just over 3 percent a year, as compared with 3.5 percent real growth assumed in the baseline. Unemployment is over 2 percent higher than the baseline forecast and is projected to be 8.9 percent in 1989. From 1982 through 1995, the low-growth path assumes productivity growth averaging 1.4 percent per year. This is similar to the growth rates experienced in the 1970s.

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[1] For a more detailed examination of the economic assumptions, see Congressional Budget Office, *The Economic Outlook* (February 1984).

CBO's projections of the Hospital Insurance trust fund under alternative economic scenarios are shown in Table 2. Both spending and income vary with the economic assumptions. Projections of the trust fund balance are less sensitive to economic assumptions, as the projection of wages and salaries plays a role in projecting both revenues and spending.

TABLE 2.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES UNDER ALTERNATIVE ECONOMIC ASSUMPTIONS

[By fiscal year, in billions of dollars]

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Baseline path:												
Total outlays	44	50	55	61	68	76	85	95	106	118	132	147
Income	46	52	61	73	73	75	79	84	89	94	98	102
Year-end balance	15	17	24	35	40	38	33	22	5	−19	−53	−97
Low-growth path:												
Total outlays	44	50	55	60	65	71	77	84	91	99	107	117
Income	46	52	60	69	67	67	69	71	71	74	74	75
Year-end balance	15	17	22	31	33	28	19	6	−14	−39	−72	−114
High-growth path:												
Total outlays	44	50	55	62	71	80	92	104	119	136	155	176
Income	46	53	63	76	78	83	91	99	107	117	127	136
Year-end balance	15	18	26	39	46	48	47	42	30	11	−17	−58

Source: CBO estimates.

Under the baseline forecast, the trust fund could be depleted in 1993. Under the high-growth path the trust fund could meet its obligations for about one additional year. Spending is higher under the high-growth path largely because prices and wages are assumed to grow at a higher rate. Revenues, however, are much higher, because of the higher inflation and wages, and the lower unemployment rates. Under this high-growth path, spending is estimated to increase at an average annual rate of about 13.5 percent from 1984 to 1995, while revenues are projected to increase at about 10.5 percent annually. The low-growth economic assumptions represents a slightly more pessimistic scenario in which the trust funds could be depleted in 1992. This economic scenario results in approximate yearly spending increases of 9.5 percent and revenue increases of 4.5 percent.

While these differences in economic assumptions cover some of the uncertainty in the trust projections, they do not account for all of it. I will turn now to some of the other important factors that could determine the growth in spending for the HI trust fund.

SENSITIVITY TO DRG RATE INCREASE

Beginning in October of 1983, hospital reimbursement under Medicare underwent a major change from a cost-based system to a system of prospective payments based on DRGs. This system was designed for gradual implementation and is expected to be fully in place by 1986. Under the new system, hospitals will be reimbursed according to a fixed rate for each of 468 different diagnosis. The 468 categories and the reimbursement levels were developed by the Secretary of Health and Human Services, and are designed to be budget-neutral through 1985. After this period the Secretary, with the advice of a special commission, will set increases in the DRG rates. Because these have not yet been determined, projection of HI spending are made more uncertain.

Another important factor in the estimates is the potential effect of the DRG system on utilization and admitting practices of hospitals. For example, hospitals could switch certain diagnosis from out-patient to in-patient care in an effort to maximize Medicare reimbursement. Estimating this effect is problematic because the system has only been in use since October 1983. During 1984, hospital reimbursement will be based only 25 percent on the regional DRG rates. The remaining 75 percent of the reimbursement will be based on hospital-specific prospective payments tied to each hospital's own historical costs. Additionally, hospitals will enter this new system over the year as their own fiscal years begin. In October 1983 only 25 percent of the hospitals had been brought onto the new system. Thus, DRGs could change their future utilization patterns and admitting patterns, as well as

making other adjustments that are important in determining the cost of Medicare hospital care. It is still too early to determine the impact.

If the DRGs have a larger or smaller impact on the costs and utilization of the program that is assumed in the CBO baseline, spending could be higher or lower than projected. Additionally, advances in medical technology could result in either more or less admissions depending on the nature of the technological change. Table 3 shows the CBO baseline projections modified by a one percentage point increase or decrease in the rate of change in Medicare hospital reimbursement. These modifications could be the result of changes in admissions, in utilization, or in the rate of increase for DRGs set by the Secretary of Health and Human Services. For example, if the growth rate in Medicare hospital reimbursement in one percentage point lower than assumed in the baseline, spending will be $0.4 billion less for the first year. The amount increases greatly every year, so that by 1989 the total difference could be $8.2 billion, and by 1995 the difference could total $57 billion. In addition, these outlay savings would result in more interest earned on the trust fund. As a result, the trust fund could be able to meet its obligations through 1994. Conversely, if the increase in hospital reimbursement was one percentage point higher than assumed in baseline, the trust fund could be depleted in 1991.

TABLE 3.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES UNDER ALTERNATIVE RATES OF INCREASE IN HOSPITAL COSTS

[By fiscal year, in billions of dollars]

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Baseline path:												
Total outlays	44	50	55	61	68	76	85	95	106	118	132	147
Income	46	52	61	73	73	75	79	84	89	94	98	102
Year-end balance	15	17	24	35	40	38	33	22	5	−19	−53	−97
Baseline path—Assuming 1 percent less increase:												
Total outlays	44	50	54	60	66	73	81	89	99	109	121	134
Income	46	52	62	73	73	76	80	86	91	97	103	108
Year-end balance	15	18	25	39	46	48	48	44	36	24	6	−19
Baseline path—Assuming 1 percent more increase:												
Total outlays	44	51	56	63	71	79	89	100	113	127	143	161
Income	46	52	61	73	72	74	78	82	86	90	93	96
Year-end balance	15	17	22	32	34	28	17	−1	−28	−65	−115	−180

Source: CBO estimates.

CBO also examined an even more optimistic and an even more pessimistic projection for the trust fund. Combining the high-growth economic path with a one percentage point lower increase in other hospital costs results in a very optimistic scenario. The pessimistic scenario combines the low-growth economic path with a one percentage point higher increase in other hospital costs. These projections are shown in Table 4. Under the best-case scenario, the trust funds are solvent throughout the projection period, although the end-of-year balances decline over the later part of the period indicating that the fund will eventually be depleted. Under the worst-case scenario, the trust fund is depleted in 1991.

TABLE 4.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES UNDER COMBINED ALTERNATIVE ECONOMIC ASSUMPTIONS AND ALTERNATIVE RATES OF INCREASE IN HOSPITAL COSTS

[By fiscal year, in billions of dollars]

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Baseline path:												
Total outlays	44	50	55	61	68	76	85	95	106	118	132	147
Income	46	52	61	73	73	75	79	84	89	94	98	102
Year-end balance	15	17	24	35	40	38	33	22	5	−19	−53	−97

TABLE 4.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES UNDER COMBINED ALTERNATIVE ECONOMIC ASSUMPTIONS AND ALTERNATIVE RATES OF INCREASE IN HOSPITAL COSTS—Continued

[By fiscal year, in billions of dollars]

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
High growth path—Assuming 1 percent less increase:												
Total outlays	44	50	55	61	68	77	87	99	111	126	142	161
Income	46	53	63	76	78	83	91	101	110	121	132	143
Year-end balance	15	18	27	42	52	58	63	65	63	58	47	29
Low growth path—Assuming 1 percent more increase:												
Total outlays	44	51	56	61	68	74	81	89	98	107	117	128
Income	46	52	60	68	66	66	67	69	69	70	70	69
Year-end balance	15	17	21	28	27	18	4	−16	−44	−81	−127	−187

Source: CBO estimates.

Finally, another significant component to be considered in estimating spending is recent trends. Since August of 1983, spending in HI has been much lower than anticipated. For the first four months of fiscal 1984, relative to the same period for 1983, outlays (adjusted for a temporary delay in Periodic Interim Payments) increased by only 7.5 percent. This decline in the rate of growth could not solely be due to the direct impact of DRGs, because they are too new to hold down the growth so significantly. If this new trend is sustained, the outlay for the trust funds could be very different from that projected.

CONCLUSION

The alternatives I have discussed demonstrate that the projections of HI spending are sensitive to many factors. As the DRG system is fully implemented, some of this uncertainty should dissipate. One factor, however, remains constant in each of these projections. Under current law, growth in spending is projected to outpace the growth in revenues so that the trust fund is likely to be either in critical condition or depleted in the early 1990s. This is the issue that must be addressed by Congress in the future.

This concludes my statement, Mr. Chairman. I will be pleased to respond to any questions you or other members of the committee may have.

Q AND A'S FOR QUESTIONS SENT TO ME BY SENATOR DOLE

Q. You and the actuaries seem to be saying approximately the same thing. Is there any difference in your estimates that you think is especially important?

A. You are correct, CBO's estimates are close to the actuaries' estimates and in fact we are both projecting that the trust fund will most likely be depleted in the early 1990s. Small differences in economic and other assumptions, result in slightly different projections of exactly when the trust fund will be depleted. Under baseline assumptions, CBO projects that the trust fund could be depleted in 1993, while the actuaries alternative II-B path shows depletion in 1991. As I pointed out in my statement, the uncertainty of the economy and other factors essential in projecting HI outlays make pinpointing a particular year for depletion very difficult.

Q. I notice that your estimate of the average annual growth rate of HI outlays appears to be somewhat higher than the intermediate forecast from the actuaries and that the main difference seems to lie in the increase in "hospital reimbursement not specifically limited by the secretary." What exactly are you referring to here?

A. CBO's estimate of yearly increase in HI outlays is slightly higher than the actuaries. This is, in part, due to the fact that CBO includes about 1.5 percent a year increase for "other factors." This component measures growth in outlays other than normal enrollment, admissions, and price increases. Because of the DRG system, CBO has lowered its projected growth for "other factors" by about ½ to 1 percent per year to 1.5 percent. As stated in my testimony, under the DRG system this growth could be the result of changing admission patterns for hospitals. In the trustees report, the actuaries state that another possible source of this increase could be adjustments in the relative payment levels for various DRGs or in the addi-

tion/deletion of DRGs in response to technology. However, while the actuaries assume that growth due to other sources will be close to zero in the future, CBO assumes it will be about 1.5 percent a year.

Q. Why do you show estimates on a fiscal year basis instead of calendar years? How much of the difference between your estimates and the actuaries estimates could be accounted for by the difference in the time basis of estimates?

A. CBO projects baseline spending and calculates cost estimates on a fiscal year basis. The HCFA actuaries have projected HI spending on both a calendar year and a fiscal year basis. The difference between their calendar and fiscal year projections is not significant. Similarly, the difference between CBO's and the actuaries' estimates are explained only to a very minor extent by calendar versus fiscal year projections.

Senator DURENBERGER. Thank you. Let me start with the conclusion that the trust fund is in trouble, and I am not going to argue that one. I would like to ask a couple of questions of both of you that really deal with the future—I mean, when it gets to the point of bankruptcy and how you have come about these estimates. That chart over there shows quite a fluctuation in the actuaries estimates, which I assume has a whole lot to do with inflation and hospital inflation and a lot of other unpredictable factors. It strikes me that in 1983 you were using 1990 as the year of depletion, and now you are using 1991. And your 1995 projections that Governor Bowen had to use were in the $200 to $300 million category, but today I hear you say probably closer to $200 and I hear the CRS probably closer to $100. So, I am curious to know why that is a lesser amount than the current projection.

Mr. KING. Senator, these are the alternative 2b projections—the trustees report contains pessimistic projections also. And the Advisory Council took note of the fact that the experience under the program has been in between the alternative 2 and the alternative 3, but closer to the alternative 2. I haven't actually estimated the deficit under the 1984 trustees report under the pessimistic alternative 3 assumptions, but in the 1983 trustees report, it was closer to $400 billion. And once again, I would like to say that we consider the 50 percent trust fund ratio to be a minimum that is needed to maintain a financially viable trust fund maintaining that trust fund ration makes the deficit somewhere between $200 and $300 billion.

Senator DURENBERGER. Somewhere in here we are dealing with total unknowns—as this election campaign will illustrate. We are dealing with having to project out 10 or 15 year inflation rates, and employment rates, and a variety of things like that. A second factor we have some trouble dealing with is what this committee and its counterparts in the Congress will do by way of cutting back on the appropriations, or the authorization for appropriations in this area.

As I indicated earlier, we propose to cut another $9 billion out of medicare this time, and I assume that is one of the factors in determining the bankruptcy dates, but there is a third factor that is of particular interest to me that I would like to explore because the witness from CBO got into a little more detail on it. I would quote briefly from page 15 of her testimony. She points out that for the first 4 months of fiscal 1984 relative to the same period of 1983, outlays increased by only 7.5 percent. This decline in the rate of growth could not be due solely to the direct impact of DRG's because they were too new to hold down the growth so significantly.

If this new trend is sustained, the outlook for the trust funds could be very different from that projected. Then, on page 4 and page 12, we see some of the things that particularly concern me in how we arrive at these projections. We talk about—at least on page 4—1.5 percent per year to allow for growth in the medicare hospital reimbursement, for changes in admitting practices of hospitals, and for increases in medical technology that have the effect of increasing admissions.

Then, we talk about a 3-percent factor that stems from projected increases in both enrollment in the program—I take it as fairly predictable unless we do something awful to the program—and the concept of utilization or hospital admission rates. And that subject is picked up in somewhat greater detail on page 12 of the testimony where you lay out the alternatives that you testified to, and a lot of that deals with how the hospitals are going to behave under this DRG system. If you assume they are going to try to game the system and try to pull a lot of outpatient business in as inpatient business or do some of this other gaming that we knew ahead of time they might try to do, then your line goes up a little faster. If we are able to deal with the DR system and with hospital behavior in the DRG system and so forth, then we ought to have some impact on that line.

If you look around the country today, and you see for example in California that there were 10,000 fewer hospital admissions last year than the previous year, there were 140 fewer hospital days per 1,000 in Blue Cross in Iowa—and let me tell you that Blue Cross is very big in Iowa—I am curious to know what is going on out there, and if lower utilization rates are causing medicare spending to slow down then why doesn't that show up in your estimates?

Mr. KING. It is too early to tell, Senator, whether lower utilization rates are causing medicare spending to go down. One thing that we do know, though, is that the reduced outlays in the first few months of fiscal year 1984 are probably due to hospitals taking longer to process their claims and perhaps in some cases intermediaries taking a little longer to process some claims that are actually paid out of the trust fund have gone down, but through a separate system that we use to measure admissions to hospitals, which is taken at the time that the data comes from the query system so that we have the data at the time the person is admitted rather than when the payment is made upon discharge. And there is no evidence from the query system that admissions are declining. There is no evidence that they are increasing any more rapidly than they had before either, but I think what you are seeing during the first few months of 1984 is a slowdown in the rate of payment to hospitals that is a cash flow effect. Now, that slowdown in cash flow could become permanent. If it does become permanent, it is not going to modify the projections very much because what is going to happen is that the trends are going to go back to the old trends once this temporary reduction in cash flow is built in. On the other hand, it could go back to normal again. If it goes back to normal, then what we will see is higher outlays than what we had expected during the latter half of fiscal year 1984 to make up for it or perhaps higher outlays than what had been expected in the first

few months of fiscal year 1985 to make up for this temporary deviation here.

Senator DURENBERGER. Let me ask our witness from CBO to expand on your thoughts and your statement in that regard. I think he probably has to work off of the statistics that come out of a computer or something. You seem to have the luxury at least from your statement to try to look at what is going on out there. Is it not a fact that, over the last year or two, we are seeing changes in hospital behavior, and we are seeing changes in admissions and in utilizations of inpatient hospitals.

Ms. CHAIKIND. We receive monthly data from the American Hospital Association. It is panel data—surveys of admissions, utilization, and admissions which show that for the over-65 population, admissions are increasing relative to last year. However, the rate of increase is smaller this year than it was last year. So, while admissions are still increasing, that increase seems to have slowed down. Length of stay, on the other hand, has declined. That obviously isn't as important a factor under a DRG system where hospitals are being paid prospectively.

Senator DURENBERGER. But in the long run it will be.

Ms. CHAIKIND. That is right. In the long run, the DRG rates would be adjusted to reflect shorter lengths of stay.

Senator DURENBERGER. Because if the Secretary operates the system correctly, it is going to be different.

Ms. CHAIKIND. That is correct, but in the short run—or at least for right now—it would not make that much of a difference. And, as Mr. King said, the billings seemed to have slowed down at the beginning of this year. You asked why have we not at this point incorporated the lower rate of growth of HI outlays into our estimates. I think that at this point it would not be advisable to take a 4-month trend and base our projections for 1995 on that trend. That would be jumping the gun. In fact, HI has been running much higher than 11 percent over the last 10 years. It has been running something more like 15 percent a year. Last year, the spending for the HI program was about 13 percent over the previous year. So, we have seen a little bit of a slowdown in the growth of HI outlays. As for the 1.5 percent per year in utilization or other factors not specifically limited by the Secretary that you mentioned, we project that to be smaller in the coming years than it has been historically. So, we have tried to incorporate to a small extent some of the recent past, although I think it is too early to say that growth in HI outlays will only be 7.5 percent per year.

Senator DURENBERGER. The value of your testimony to me, and you do put some percentages on it, is that you are telling us that if we all—those of us who make policy on payment and the providers—deal with issues like admitting practices, deal with issues like the increase in medical technology, and deal with the issue of utilization and so forth, and we can affect that growth line somewhat substantially.

Ms. CHAIKIND. Those are options that would be available. Yes, sir.

Senator DURENBERGER. OK. Thank you very much.

Senator PACKWOOD. No questions. Thank you very much.

Next, we will take Dr. Otis R. Bowen, who is the Chairperson of the 1982 Advisory Council on Social Security and the former Governor of the State of Indiana, and he is accompanied by Thomas R. Burke, the Executive Director of the Advisory Council on Social Security.

It is good to have you with us this morning, Governor.

STATEMENT OF OTIS R. BOWEN, M.D., CHAIRPERSON, 1982 ADVISORY COUNCIL ON SOCIAL SECURITY, INDIANAPOLIS, IN, ACCOMPANIED BY RICHARD RAHN AND THOMAS R. BURKE

Dr. BOWEN. Thank you very much, Senator. Mr. Chairman and members of the Senate Finance Committee, as has been stated, I am Otis R. Bowen, the former Governor of Indiana, and Chairman of the Advisory Council on Social Security. I am accompanied today by Mr. Richard Rahn, a member of our committee, on my left, and on my right, Mr. Thomas R. Burke, who is the Executive Director of the Council.

I am here to report on the findings and recommendations of the Council, and with your permission, Mr. Chairman, I shall try to keep my prepared remarks brief in order to conserve time and to allow for questions you may have regarding one or more of the several recommendations that the Council is proposing. Medicare is the Nation's largest federally financed health insurance program, serving approximately 30 million elderly and disabled Americans.

One of the most successful social programs, it has provided basic protection against the costs of health care for a significant portion of the population. However, the continued escalation of health care costs and an increasing elderly population have placed extraordinary demands on the program and its resources that were not anticipated when the program began in 1966. If we are to ensure that medicare will continue to meet the needs of our elderly and disabled citizens, prompt action is required to restore its financial position. When the Advisory Council on Social Security was appointed in September of 1982 by the then-Secretary of Health and Human Services, Richard Schweiker, it was directed by its charter to place particular emphasis on the review or the Medicare Program. The Council took its charter very seriously, devoting more than a year to intensive deliberations involving 14 meetings and eight public hearings.

Our public hearings were held in cities throughout the United States, including San Francisco, Evanston, St. Petersburg, and New Brunswick. The Council has developed a series of recommendations that we believe will both alleviate the financial problems currently confronting the program and improve its reponsiveness to the needs of program beneficiaries. The Council is making 26 different recommendations. We operated under a considerable time constraint, and we were not able to address every health care issue that probably should have been addressed.

We have nonetheless come up with a plan for rescuing the financially burdened Medicare Program. And I certainly am not here today to say that this is a perfect plan or the only plan, but I do believe we have provided an agenda that I hope you, as Members of Congress, will seriously consider as you address this important na-

tional issue. We have undertaken extensive staff work which we believe should be of assistance to your staff in tackling this problem, a problem we know is very quickly going to confront the entire country, particularly the elderly and disabled Americans who are served by the Medicare Program.

To put the program in perspective, the Council adopted a working assumption that the hospital insurance trust fund would experience a cumulative deficit of $200 to $300 billion by the end of 1995. And this estimate was based on information provided by the 1983 annual report of the medicare board of trustees, estimates issued by the Congressional Budget Office, and additional information provided by the Health Care Financing Administration's Office of Financial and Actuarial Analysis. Although some recent estimates indicate that the point of insolvency may be delayed a few years, the time frame in which action is necessary is already close at hand.

The Council recommendations are categorized into six general areas—financing, eligibility, benefit structure, reimbursement, issues general in nature, and issues deserving further study. Let me now highlight some of the more significant recommendations of the Council.

In addressing the benefit structure of the Medicare Program, the Council's principal objectives were to provide improved catastrophic protection for all beneficiaries, to simplify as much as possible the benefit package, to incorporate reasonable cost-sharing by beneficiaries, to identify ways to alleviate the financial crisis facing the hospital insurance trust fund. And we believe that our recommended restructured benefit package will accomplish these objectives and will do so by using traditional health insurance concepts that spread the risk of liability for increased costs across all beneficiaries who will be eligible for the improved benefits recommended.

We reviewed a variety of cost-sharing approaches that provided for increased coinsurance during shorter, more typical hospital inpatient stays, to finance improved catastrophic protection, and produce savings for the trust fund. Our major problem with these approaches was that the improved catastrophic benefit protection that would be made available to all would only be financed by a minority of the beneficiary population who actually used inpatient services. Instead, the Council recommends that a new basic part A hospital insurance protection be provided to all beneficiaries based on the payroll or self-employed tax contributions they make during their lifetime. and for those who elect only part A hospital insurance, this new benefit would provide, (1), unlimited days of inpatient hospital care; (2), 100 days per year of care in a skilled nursing facility, (3), all of the currently offered home health, and, (4), hospice benefits. No. 5, a preadmisssion hospital inpatient deductible as currently computed would apply but for no more than two admissions in a year. Further, a daily coinsurance equal to 3 percent of the deductible would apply to all days used with the exception of the day of admission when the deductible was collected. The current 12.5 percent coinsurance on the 21st through 100th day of care in a skilled nursing facility would continue to apply. With this as a basic restructure, the Council further recommends that all beneficiaries who elect medicare part B, supplementary medical in-

surance—and about 95 percent of them do now—that they automatically receive for an additional annual premium an improved part A benefit.

This improved part A benefit would eliminate liability for the daily 3 percent coinsurance on hospital inpatient days and the 12.5 percent coinsurance on applicable skilled nursing facility days of care. In effect, their cost-sharing liability would be limited to the admission deductible and a maximum of two such deductibles per year. The added premium, which we estimate would be approximately $98.00 in 1985, would finance the costs of catastrophic protection and the cost-sharing limits and would also provide additional program revenues that will help to alleviate the growing deficits in the part A trust fund. Under this plan, the improved part A benefit—that is, the unlimited days of inpatient hospital care with very limited cost-sharing—would be supported by the substantial majority of all beneficiaries and not just those who require and use inpatient hospital services in a given year.

The Council also recommends a plan for providing improved catastrophic protection for part B supplementary medical care expenses. The unpredictable and potentially substantial cost sharing that can occur under part B of the program was a frequently cited concern of beneficiaries at several public hearings that the Council conducted. Under the Council's plan, the beneficiary electing part B would have the option—it would not be required as part of the part B election—but it would have the option to purchase a supplemental plan that would establish an annual dollar limit—$227 per year in 1985—on their cost-sharing liability for approved medicare part B charges. The premium for this protection, assuming that a substantial percentage of medicare beneficiaries opted for it, would be approximately $150 per year in 1985.

In summary, under the Council's recommended restructure plan, all beneficiaries eligible for part A hospital insurance would receive catastrophic protection. For an additional $98 per year premium in 1985, those beneficiaries enrolling in part B would also be relieved of liability for cost sharing beyond the inpatient deductible. Beneficiaries who also elected the optional part B supplement would also limit their cost-sharing liability under part B. Although some beneficiaries would experience an increase in the medicare premiums they now pay of approximately $250 per year, we believe beneficiaries who supplement their medicare coverage with private medigap insurance—and over 70 percent do so now—will actually realize a net savings in the cost of their health insurance protection. Most medigap policies are priced from $300 to $600 a year, with those at the higher end of this range being typical.

The net effect on the part A trust fund of the above recommendations over the next 10 years is estimated to be approximately $38 billion. This includes some $25 billion in additional revenues and $13 billion in reduced expenditures.

Under benefit restructuring the Council also endorses a concept of voluntary vouchers since it perceives that this would enhance competition in the health care field. However, precautions should be taken to ensure that coverage would at least be as comprehensive as current coverage and that use of the voucher be entirely

voluntary. Voluntary vouchers are estimated to cost approximately $50 million to implement.

Also, the Council is recommending that the part B deductible be indexed to the consumer price index, that is, when the Social Security benefits are increased, the part B deductible, which is currently $75, would also be increased by the same percentage. Indexing of the part B deductible would have no impact on the part A trust fund shortfall. However, if begun in 1985, the part B trust fund would realize accumulated savings of approximately $680 million by the end of fiscal year 1989.

A second major group of recommendations of the Council addresses medicare reimbursement policies. The Council endorses the concept of prospective payment and did so prior to the enactment of the Social Security Amendments of 1983. The Council recommends, however, that the rate of increase in DRG payment be limited to the hospital input price index and not the hospital input price index plus 1 percent, as is currently the law. It is estimated that this restricting the increase in DRG's to the hospital input price index would save about $34.5 billion by 1995.

Another recommendation which may prove to be controversial would eliminate medicare's reimbursement for medical and other professional health education expenses incurred by hospitals. It is the belief of the Council that it is inappropriate for a health care program designed to provide care for elderly and disabled Americans to be subsidizing such education expenses. The Council fully recognizes the importance of medical education and the need for continued Federal support. However, it believes that these costs should be funded through other Federal, State, or local programs and not by the Medicare Program.

Another major recommendation of the Council, which is not expected to generate any savings, but is a consequence of the extensive testimony that Council heard throughout the United States, concerns medicare's physician assignment policy. The Council is recommending that physicians annually be given the option either to elect to participate or not to participate in the Medicare Program. Those physicians who elect to participate would agree to accept medicare payment as payment in full and not bill the beneficiaries for the difference between their charges and what medicare considers reasonable and allowable, that is, customary, prevailing, and reasonable charges.

If a physician does not participate, the medicare payment would be made to the patient, who would then be responsible for paying the physician's bill. A physician would be given the option to elect to participate. However, he or she could terminate the participation agreement by providing medicare with 180 days of notice. In return for agreement to participate, the Council further recommends that HCFA publish local directories of participating physicians in every major locality. The directory would indentify by medical specialty those physicians who have agreed to participate in the program. As added incentives, medicare would allow for batch billing or subsidized electronic billing by participating physicians and would provide for electronic funds transfer of payments to provide a more predictable cash flow for participating physicians.

Under the category of financing, the Council opposes increasing payroll taxes beyond currently legislated levels to pay for the projected deficit in the medicare trust fund. However, we do endorse the taxation of a portion of the employer-provided health insurance similar to the proposal submitted by the Reagan administration last year. The Council does not view revenue raising as a primary benefit of this proposal. Rather, Council members believe that, over the long run, consumers will choose more cost-effective types of care, thus decreasing the overall rate of growth in health care costs.

A bare majority of the Council also recommends increasing the Federal excise tax on alcohol and tobacco products. The rationale for this latter recommendation is the increasing evidence that these two products cause significant increases in health care expenditures, and if additional revenues are needed, current excise taxes should be increased and earmarked for the hospital insurance trust fund to help solve the medicare shortfall. Two Senators, including one member of the committee, testified against such increased excise taxes, noting the negative effects on the industries involved and pointing out that this is the prerogative of the States as a source of revenue. In the final analysis, however, the Council believes that some additional source of revenue should be identified and that an increased excise tax is the least objectionable of the available alternatives.

The eligibility recommendations of the Council include perhaps the most controversial recommendation of the Council, gradually advancing the age of eligibility for medicare from age 65 to age 67 over the next 5 years. If implemented, this recommendation would produce about $75 billion in medicare savings over the next 10 years. Since the Medicare Program began, the average lifespan has increased more than 3 years, and this increase in life expectancy has major implications for the Medicare Program.

As you know, the ratio of workers contributing to the trust funds to beneficiaries collecting benefits continues to decline. The expanding population, combined with the increasing longevity of that population, places a particularly severe financial burden on medicare as health care costs increase with age. The Council recognizes that recent changes in the age of eligibility for cash retirement benefits will be implemented over a 40-year period. However, the Council believes that to continue to have a viable Medicare Program, more immediate changes in the age of eligibility for medicare are necessary.

Finally, the Council endorses the concept of advanced directives or living wills, which are currently recognized by law in 14 States. The Council called for a study to look at the impact on health expenditures in those States having such laws and encouraged other States to adopt similar legislation. Living wills would prevent unnecessarily heroic measures being taken in the terminal days of life. Eleven percent of medicare expenditures are spent in the last 40 days of life, and 23 percent in the last 6 months, and 30 percent of medicare expenditures are incurred by patients in the last year of life. The Council fully recognizes that this may be a controversial recommendation. However, the Council unanimously endorsed it.

The Council's recommendations I have just reviewed would, if enacted, eliminate the financial burden of the hospital insurance trust fund. If those recommendations whose savings or revenues have been quantified were to be implemented promptly, the trust fund would be solvent in 1995 with a moderate reserve to guard against contingencies. Those recommendations which have not been quantified represent, in our view, viable alternative sources of revenue in the event of delays or failure to adopt portions of the quantified package.

Mr. Chairman, that covers the highlights of the more significant recommendations of the Council. And as you are aware, there are several others which I will be happy to discuss with you. I do wish to note that, in addition to our formal recommendations, the Council did identify several issues which they viewed as deserving of future study by the Department of Health and Human Services.

These are spelled out in the Council report and include some suggested alternatives for a longer term restructuring of the Medicare Program. Thank you very much.

[The prepared written statement of Dr. Bowen follows:]

STATEMENT

BY OTIS R. BOWEN, M.D.

CHAIRPERSON

ADVISORY COUNCIL ON SOCIAL SECURITY

BEFORE THE SENATE COMMITTEE

ON FINANCE

APRIL 9, 1984

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE ON FINANCE, I AM OTIS BOWEN FORMER GOVERNOR OF INDIANA AND CHAIRPERSON OF THE ADVISORY COUNCIL ON SOCIAL SECURITY. I AM ACCOMPANIED TODAY BY MR. SAMUEL H. HOWARD, A MEMBER OF THE COUNCIL, AND MR. THOMAS R. BURKE, THE COUNCIL'S EXECUTIVE DIRECTOR. I AM HERE TO REPORT ON THE FINDINGS AND RECOMMENDATIONS OF THE COUNCIL. WITH YOUR PERMISSION MR. CHAIRMAN, I SHALL TRY TO KEEP MY PREPARED REMARKS BRIEF IN ORDER TO CONSERVE TIME AND ALLOW FOR QUESTIONS YOU MAY HAVE REGARDING ONE OR MORE OF THE SEVERAL RECOMMENDATIONS THAT THE COUNCIL IS PROPOSING.

MEDICARE IS THE NATION'S LARGEST FEDERALLY FINANCED HEALTH INSURANCE PROGRAM SERVING APPROXIMATELY 30 MILLION ELDERLY AND DISABLED AMERICANS. ONE OF THE MOST SUCCESSFUL SOCIAL PROGRAMS, IT HAS PROVIDED BASIC PROTECTION AGAINST THE COSTS OF HEALTH CARE FOR A

SIGNIFICANT PORTION OF THE POPULATION. HOWEVER, THE CONTINUED ESCALATION OF HEALTH CARE COSTS AND AN INCREASING ELDERLY POPULATION HAVE PLACED EXTRAORDINARY DEMANDS ON THE PROGRAM AND ITS RESOURCES THAT WERE NOT ANTICIPATED WHEN THE PROGRAM BEGAN IN 1966. IF WE ARE TO INSURE THAT MEDICARE WILL CONTINUE TO MEET THE NEEDS OF OUR ELDERLY AND DISABLED CITIZENS, PROMPT ACTION IS REQUIRED TO RESTORE ITS FINANCIAL POSITION.

WHEN THE ADVISORY COUNCIL ON SOCIAL SECURITY WAS APPOINTED IN SEPTEMBER OF 1982 BY THE THEN SECRETARY OF HEALTH AND HUMAN SERVICES, RICHARD SCHWEIKER, IT WAS DIRECTED BY ITS CHARTER TO PLACE PARTICULAR EMPHASIS ON A REVIEW OF THE MEDICARE PROGRAM. THE COUNCIL TOOK ITS CHARTER VERY SERIOUSLY DEVOTING MORE THAN A YEAR TO INTENSIVE DELIBERATIONS, INVOLVING 14 MEETINGS AND 8 PUBLIC HEARINGS. OUR PUBLIC HEARINGS WERE HELD IN CITIES THROUGHOUT THE UNITED STATES INCLUDING SAN FRANCISCO, CALIFORNIA, EVANSTON, ILLINOIS, ST. PETERSBURG, FLORIDA AND NEW BRUNSWICK, NEW JERSEY. THE COUNCIL HAS DEVELOPED A SERIES OF RECOMMENDATIONS THAT WE BELIEVE WILL BOTH ALLEVIATE THE FINANCIAL PROBLEMS CURRENTLY CONFRONTING THE PROGRAM AND IMPROVE ITS RESPONSIVENESS TO THE NEEDS OF PROGRAM BENEFICIARIES.

THE COUNCIL IS MAKING TWENTY-SIX DIFFERENT RECOMMENDATIONS. WE OPERATED UNDER A CONSIDERABLE TIME CONSTRAINT AND WERE NOT ABLE TO ADDRESS EVERY HEALTH CARE ISSUE THAT PROBABLY SHOULD HAVE BEEN

ADDRESSED. WE HAVE, NONETHELESS, COME UP WITH A PLAN FOR RESCUING THE FINANCIALLY BURDENED MEDICARE PROGRAM. I AM NOT HERE TODAY TO SAY THAT THIS IS A PERFECT PLAN OR THE ONLY PLAN, BUT I DO BELIEVE WE HAVE PROVIDED AN AGENDA THAT I HOPE YOU, AS MEMBERS OF CONGRESS, WILL SERIOUSLY CONSIDER AS YOU ADDRESS THIS IMPORTANT NATIONAL ISSUE. WE HAVE UNDERTAKEN EXTENSIVE STAFF WORK WHICH WE BELIEVE SHOULD BE OF ASSISTANCE TO YOUR STAFF IN TACKLING THIS PROBLEM, A PROBLEM WE KNOW IS VERY QUICKLY GOING TO CONFRONT THE ENTIRE COUNTRY, PARTICULARLY THE ELDERLY AND DISABLED AMERICANS WHO ARE SERVED BY THE MEDICARE PROGRAM.

TO PUT THE PROBLEM IN PERSPECTIVE, THE COUNCIL ADOPTED A WORKING ASSUMPTION THAT THE HOSPITAL INSURANCE TRUST FUND WOULD EXPERIENCE A CUMULATIVE DEFICIT OF $200 TO $300 BILLION BY THE END OF 1995. THIS ESTIMATE WAS BASED ON INFORMATION PROVIDED BY THE 1983 ANNUAL REPORT OF THE MEDICARE BOARD OF TRUSTEES, ESTIMATES ISSUED BY THE CONGRESSIONAL BUDGET OFFICE AND ADDITIONAL INFORMATION PROVIDED BY THE HEALTH CARE FINANCING ADMINISTRATION'S OFFICE OF FINANCIAL AND ACTUARIAL ANALYSIS. ALTHOUGH SOME RECENT ESTIMATES INDICATE THAT THE POINT OF INSOLVENCY MAY BE DELAYED A FEW YEARS, THE TIME FRAME IN WHICH ACTION IS NECESSARY IS ALREADY CLOSE AT HAND.

THE COUNCIL RECOMMENDATIONS ARE CATEGORIZED INTO SIX GENERAL AREAS, FINANCING, ELIGIBILITY, BENEFIT STRUCTURE, REIMBURSEMENT, ISSUES

GENERAL IN NATURE AND ISSUES DESERVING FURTHER STUDY. LET ME NOW HIGHLIGHT SOME OF THE MORE SIGNIFICANT RECOMMENDATIONS OF THE COUNCIL.

IN ADDRESSING THE BENEFIT STRUCTURE OF THE MEDICARE PROGRAM THE COUNCIL'S PRINCIPAL OBJECTIVES WERE TO PROVIDE IMPROVED CATASTROPHIC PROTECTION FOR ALL BENEFICIARIES; TO SIMPLIFY, AS MUCH AS POSSIBLE, THE BENEFIT PACKAGE; TO INCORPORATE REASONABLE COST-SHARING BY BENEFICIARIES; TO IDENTIFY WAYS TO ALLEVIATE THE FINANCIAL CRISIS FACING THE HOSPITAL INSURANCE TRUST FUND.

WE BELIEVE THAT OUR RECOMMENDED RESTRUCTURED BENEFIT PACKAGE WILL ACCOMPLISH THESE OBJECTIVES AND WILL DO SO BY USING TRADITIONAL HEALTH INSURANCE CONCEPTS THAT SPREAD THE RISK AND LIABILITY FOR INCREASED COSTS ACROSS ALL BENEFICIARIES WHO WILL BE ELIGIBLE FOR THE IMPROVED BENEFITS RECOMMENDED.

WE REVIEWED A VARIETY OF COST-SHARING APPROACHES THAT PROVIDED FOR INCREASED COINSURANCE DURING SHORTER MORE TYPICAL HOSPITAL INPATIENT STAYS TO FINANCE IMPROVED CATASTROPHIC PROTECTION AND PRODUCE SAVINGS FOR THE TRUST FUND. OUR MAJOR PROBLEM WITH THESE APPROACHES WAS THAT THE IMPROVED CATASTROPHIC BENEFIT PROTECTION THAT WOULD BE MADE AVAILABLE TO ALL WOULD ONLY BE FINANCED BY A MINORITY OF THE BENEFICIARY POPULATION WHO ACTUALLY USE INPATIENT SERVICES.

INSTEAD THE COUNCIL RECOMMENDS THAT A NEW BASIC PART A HOSPITAL INSURANCE PROTECTION BE PROVIDED TO ALL BENEFICIARIES BASED ON THE PAYROLL OR SELF EMPLOYED TAX CONTRIBUTIONS THEY MAKE DURING THEIR LIFE TIME. FOR THOSE WHO ELECT ONLY PART A HOSPITAL INSURANCE THIS NEW BENEFIT WOULD PROVIDE UNLIMITED DAYS OF INPATIENT HOSPITAL CARE, 100 DAYS PER YEAR OF CARE IN A SKILLED NURSING FACILITY, AND ALL OF THE CURRENTLY OFFERED HOME HEALTH AND HOSPICE BENEFITS. A PER ADMISSION HOSPITAL INPATIENT DEDUCTIBLE, AS CURRENTLY COMPUTED, WOULD APPLY BUT FOR NO MORE THAN TWO ADMISSIONS A YEAR. FURTHER, A DAILY COINSURANCE EQUAL TO 3 PERCENT OF THE DEDUCTIBLE, WOULD APPLY TO ALL DAYS USED WITH THE EXCEPTION OF THE DAY OF ADMISSION WHEN A DEDUCTIBLE WAS COLLECTED. THE CURRENT 12.5 PERCENT COINSURANCE ON APPLICABLE SKILLED NURSING FACILITY DAYS OF CARE, WOULD CONTINUE TO APPLY.

WITH THIS AS A BASIC RESTRUCTURE, THE COUNCIL FURTHER RECOMMENDS THAT ALL BENEFICIARIES WHO ELECT MEDICARE PART B, SUPPLEMENTARY MEDICAL INSURANCE, (ABOUT 95 PERCENT NOW DO) AUTOMATICALLY RECEIVE, FOR AN ADDITIONAL ANNUAL PREMIUM, AN IMPROVED PART A BENEFIT. THE IMPROVED PART A BENEFIT WOULD ELIMINATE LIABILITY FOR THE DAILY 3 PERCENT COINSURANCE ON HOSPITAL INPATIENT DAYS AND THE 12.5 PERCENT COINSURANCE ON APPLICABLE SKILLED NURSING FACILITY DAYS OF CARE. IN EFFECT THEIR COST SHARING LIABILITY WOULD BE LIMITED TO THE ADMISSION DEDUCTIBLE AND A MAXIMUM OF TWO SUCH DEDUCTIBLES PER CALENDAR YEAR.

THE ADDED PREMIUM, WHICH WE ESTIMATE WOULD BE APPROXIMATELY $98 IN 1985, WOULD FINANCE THE COSTS OF CATASTROPHIC PROTECTION AND THE COST-SHARING LIMITS AND WOULD ALSO PROVIDE ADDITIONAL PROGRAM REVENUES THAT WILL HELP TO ALLEVIATE THE GROWING DEFICITS IN THE PART A TRUST FUND.

UNDER THIS PLAN THE IMPROVED PART A BENEFIT, I.E., UNLIMITED DAYS OF INPATIENT HOSPITAL CARE WITH VERY LIMITED COST-SHARING WOULD BE SUPPORTED BY THE SUBSTANTIAL MAJORITY OF ALL BENEFICIARIES, NOT JUST THOSE WHO REQUIRE AND USE INPATIENT HOSPITAL SERVICES IN A GIVEN YEAR.

THE COUNCIL ALSO RECOMMENDS A PLAN FOR PROVIDING IMPROVED CATASTROPHIC PROTECTION FOR PART B SUPPLEMENTARY MEDICAL CARE EXPENSES. THE UNPREDICTABLE AND POTENTIALLY SUBSTANTIAL COST SHARING THAT CAN OCCUR UNDER PART B OF THE PROGRAM WAS A FREQUENTLY CITED CONCERN OF BENEFICIARIES AT SEVERAL PUBLIC HEARINGS THAT THE COUNCIL CONDUCTED. UNDER THE COUNCIL'S PLAN THE BENEFICIARY ELECTING PART B WOULD HAVE THE OPTION--IT WOULD NOT BE REQUIRED AS PART OF THE PART B ELECTION--TO PURCHASE A SUPPLEMENTAL PLAN THAT WOULD ESTABLISH AN ANNUAL DOLLAR LIMIT ($227 PER YEAR IN 1985) ON THEIR COST-SHARING LIABILITY FOR APPROVED MEDICARE PART B CHARGES. THE PREMIUM FOR THIS PROTECTION, ASSUMING THAT A SUBSTANTIAL PERCENTAGE OF MEDICARE BENEFICIARIES OPTED FOR IT, WOULD BE APPROXIMATELY $150 PER YEAR IN 1985.

IN SUMMARY, UNDER THE COUNCIL'S RECOMMENDED RESTRUCTURE PLAN ALL BENEFICIARIES ELIGIBLE FOR PART A HOSPITAL INSURANCE WOULD RECEIVE CATASTROPHIC PROTECTION. FOR AN ADDITIONAL $98 PER YEAR PREMIUM IN 1985, THOSE BENEFICIARIES ENROLLING IN PART B WOULD ALSO BE RELIEVED OF LIABILITY FOR COST SHARING BEYOND THE INPATIENT DEDUCTIBLE.

BENEFICIARIES WHO ALSO ELECTED THE OPTIONAL PART B SUPPLEMENT WOULD ALSO LIMIT THEIR COST-SHARING LIABILITY UNDER PART B. ALTHOUGH SUCH BENEFICIARIES WOULD EXPERIENCE AN INCREASE IN THE MEDICARE PREMIUMS THEY NOW PAY OF APPROXIMATELY $250 PER YEAR, WE BELIEVE BENEFICIARIES WHO SUPPLEMENT THEIR MEDICARE COVERAGE WITH PRIVATE "MEDIGAP" INSURANCE, AND OVER 70% DO SO NOW, WILL ACTUALLY REALIZE A NET SAVINGS IN THE COST OF THEIR HEALTH INSURANCE PROTECTION. MOST MEDIGAP POLICIES ARE PRICED FROM $300 TO $600 PER YEAR WITH THOSE AT THE HIGHER END OF THIS RANGE BEING TYPICAL.

THE NET EFFECT ON THE PART A TRUST FUND OF THE ABOVE RECOMMENDATIONS OVER THE NEXT 10 YEARS IS ESTIMATED TO BE APPROXIMATELY 38 BILLION DOLLARS. THIS INCLUDES SOME 25 BILLION DOLLARS IN ADDITIONAL REVENUES AND 13 BILLION DOLLARS IN REDUCED EXPENDITURES.

UNDER BENEFIT RESTRUCTURING THE COUNCIL ALSO ENDORSES THE CONCEPT OF VOLUNTARY VOUCHERS SINCE IT PERCEIVES THAT THIS WOULD ENHANCE COMPETITION IN THE HEALTH CARE FIELD. HOWEVER, PRECAUTIONS SHOULD

BE TAKEN TO ENSURE THAT COVERAGE WOULD BE AT LEAST AS COMPREHENSIVE AS CURRENT COVERAGE AND THAT USE OF THE VOUCHER BE ENTIRELY VOLUNTARY. VOLUNTARY VOUCHERS ARE ESTIMATED TO COST APPROXIMATELY 50 MILLION DOLLARS TO IMPLEMENT.

ALSO, THE COUNCIL IS RECOMMENDING THAT THE PART B DEDUCTIBLE BE INDEXED TO THE CONSUMER PRICE INDEX. THAT IS, WHEN THE SOCIAL SECURITY BENEFITS ARE INCREASED, THE PART B DEDUCTIBLE WHICH IS CURRENTLY 75 DOLLARS WOULD ALSO BE INCREASED BY THE SAME PERCENTAGE. INDEXING OF THE PART B DEDUCTIBLE WOULD HAVE NO IMPACT ON THE PART A TRUST FUND SHORTFALL. HOWEVER, IF BEGUN IN 1985, THE PART B TRUST FUND WOULD REALIZE ACCUMULATED SAVINGS OF APPROXIMATELY 680 MILLION DOLLARS BY THE END OF FISCAL YEAR 1989.

A SECOND MAJOR GROUP OF RECOMMENDATIONS OF THE COUNCIL ADDRESS MEDICARE REIMBURSEMENT POLICIES. THE COUNCIL ENDORSES THE CONCEPT OF PROSPECTIVE PAYMENT AND DID SO PRIOR TO THE ENACTMENT OF THE SOCIAL SECURITY AMENDMENTS OF 1983. THE COUNCIL RECOMMENDS, HOWEVER, THAT THE RATE OF INCREASE IN DRG PAYMENT BE LIMITED TO THE HOSPITAL INPUT PRICE INDEX AND NOT THE HOSPITAL INPUT PRICE INDEX PLUS ONE PERCENT AS IS CURRENTLY IN THE LAW. IT IS ESTIMATED THAT RESTRICTING THE INCREASE IN DRGS TO THE HOSPITAL INPUT PRICE INDEX WOULD SAVE SOME 34.5 BILLION DOLLARS BY 1995.

ANOTHER RECOMMENDATION, WHICH MAY PROVE TO BE CONTROVERSIAL, WOULD ELIMINATE MEDICARE'S REIMBURSEMENT FOR MEDICAL AND OTHER PROFESSIONAL HEALTH EDUCATION EXPENSES INCURRED BY HOSPITALS. IT IS THE BELIEF OF THE COUNCIL THAT IT IS INAPPROPRIATE FOR A HEALTH CARE PROGRAM DESIGNED TO PROVIDE CARE FOR ELDERLY AND DISABLED AMERICANS TO BE SUBSIDIZING SUCH EDUCATION EXPENSES. THE COUNCIL FULLY RECOGNIZES THE IMPORTANCE OF MEDICAL EDUCATION AND THE NEED FOR CONTINUED FEDERAL SUPPORT; HOWEVER, IT BELIEVES THAT THESE COSTS SHOULD BE FUNDED THROUGH OTHER FEDERAL, STATE OR LOCAL PROGRAMS AND NOT BY THE MEDICARE PROGRAM.

ANOTHER MAJOR RECOMMENDATION OF THE COUNCIL WHICH IS NOT EXPECTED TO GENERATE ANY SAVINGS BUT IS A CONSEQUENCE OF THE EXTENSIVE TESTIMONY THE COUNCIL HEARD THROUGHOUT THE UNITED STATES CONCERNS MEDICARE'S PHYSICIAN ASSIGNMENT POLICY. THE COUNCIL IS RECOMMENDING THAT PHYSICIANS ANNUALLY BE GIVEN THE OPTION TO EITHER ELECT TO PARTICIPATE OR NOT TO PARTICIPATE IN THE MEDICARE PROGRAM. THOSE PHYSICIANS WHO ELECT TO PARTICIPATE WOULD AGREE TO ACCEPT MEDICARE PAYMENT AS PAYMENT IN FULL AND NOT BILL THE BENEFICIARIES FOR THE DIFFERENCE BETWEEN THEIR CHARGES AND WHAT MEDICARE CONSIDERS REASONABLE AND ALLOWABLE (CUSTOMARY, PREVAILING AND REASONABLE CHARGES). IF A PHYSICIAN DOES NOT PARTICIPATE, THE MEDICARE PAYMENT WOULD BE MADE TO THE PATIENT WHO WOULD THEN BE RESPONSIBLE FOR

PAYING THE PHYSICIAN'S ENTIRE BILL. A PHYSICIAN WOULD BE GIVEN THE OPTION TO ELECT TO PARTICIPATE; HOWEVER, HE OR SHE COULD TERMINATE THE PARTICIPATION AGREEMENT BY PROVIDING MEDICARE WITH 180 DAY NOTICE. IN RETURN FOR AGREEMENT TO PARTICIPATE THE COUNCIL FURTHER RECOMMENDS THAT THE HCFA PUBLISH LOCAL DIRECTORIES OF PARTICIPATING PHYSICIANS IN EVERY MAJOR LOCALITY. THE DIRECTORY WOULD IDENTIFY BY MEDICAL SPECIALTY THOSE PHYSICIANS WHO HAVE AGREED TO PARTICIPATE IN THE PROGRAM. AS ADDED INCENTIVES MEDICARE WOULD ALLOW FOR BATCH BILLING OR SUBSIDIZED ELECTRONIC BILLING BY PARTICIPATING PHYSICIANS AND WOULD PROVIDE FOR ELECTRONIC FUNDS TRANSFER OF PAYMENTS TO PROVIDE A MORE PREDICTABLE CASH FLOW FOR PARTICIPATING PHYSICIANS.

UNDER THE CATEGORY OF FINANCING, THE COUNCIL OPPOSES INCREASING PAYROLL TAXES BEYOND CURRENTLY LEGISLATED LEVELS TO PAY FOR THE PROJECTED DEFICIT IN THE MEDICARE TRUST FUND.

HOWEVER, WE DO ENDORSE THE TAXATION OF A PORTION OF EMPLOYER PROVIDED HEALTH INSURANCE SIMILAR TO THE PROPOSAL SUBMITTED BY THE REAGAN ADMINISTRATION LAST YEAR. THE COUNCIL DOES NOT VIEW REVENUE RAISING AS THE PRIMARY BENEFIT OF THIS PROPOSAL. RATHER, COUNCIL MEMBERS BELIEVE THAT OVER THE LONG RUN CONSUMERS WILL CHOOSE MORE COST-EFFECTIVE TYPES OF CARE, THUS DECREASING THE OVERALL RATE OF GROWTH IN HEALTH CARE COSTS.

A MAJORITY OF THE COUNCIL ALSO RECOMMENDS INCREASING THE FEDERAL EXCISE TAX ON ALCOHOL AND TOBACCO PRODUCTS. THE COUNCIL RATIONALE FOR ITS RECOMMENDATION IS THE INCREASING EVIDENCE THAT THESE TWO PRODUCTS CAUSE SIGNIFICANT INCREASES IN HEALTH CARE EXPENDITURES AND IF ADDITIONAL REVENUES ARE NEEDED, CURRRENT EXCISE TAXES SHOULD BE INCREASED AND EARMARKED TO THE HOSPITAL INSURANCE TRUST FUND TO HELP SOLVE THE MEDICARE SHORTFALL. TWO SENATORS, INCLUDING ONE MEMBER OF THIS COMMITTEE TESTIFIED AGAINST SUCH INCREASED EXCISE TAXES, NOTING THE NEGATIVE EFFECTS ON THE INDUSTRIES INVOLVED AND POINTING OUT THAT THIS HAS TRADITIONALLY BEEN THE PREROGATIVE OF THE STATES AS A SOURCE OF REVENUE. IN THE FINAL ANALYSIS, HOWEVER, THE COUNCIL BELIEVES THAT SOME ADDITIONAL SOURCE OF REVENUE SHOULD BE IDENTIFIED AND THAT AN INCREASED EXCISE TAX IS THE LEAST OBJECTIONABLE OF THE AVAILABLE ALTERNATIVES.

THE ELIGIBILITY RECOMMENDATIONS OF THE COUNCIL INCLUDE PERHAPS THE MOST CONTROVERSIAL RECOMMENDATION OF THE COUNCIL, ADVANCING THE AGE OF ELIGIBILITY FOR MEDICARE FROM AGE 65 TO AGE 67 OVER THE NEXT FIVE YEARS. IF IMPLEMENTED THIS RECOMMENDATION WOULD PRODUCE ABOUT 75 BILLION DOLLARS IN MEDICARE SAVINGS OVER THE NEXT TEN YEARS.

SINCE THE MEDICARE PROGRAM BEGAN, THE AVERAGE LIFE SPAN HAS INCREASED MORE THAN 3 YEARS. THIS INCREASE IN LIFE EXPECTANCY HAS MAJOR IMPLICATIONS FOR THE MEDICARE PROGRAM. AS YOU KNOW, THE RATIO OF WORKERS CONTRIBUTING TO THE TRUST FUNDS TO BENEFICIARIES

COLLECTING BENEFITS CONTINUES TO DECLINE. THE EXPANDING POPULATION COMBINED WITH THE INCREASING LONGEVITY OF THAT POPULATION PLACES A PARTICULARLY SEVERE FINANCIAL BURDEN ON MEDICARE AS HEALTH CARE COSTS INCREASE WITH AGE. THE COUNCIL RECOGNIZES THAT RECENT CHANGES IN THE AGE OF ELIGIBILITY FOR CASH RETIREMENT BENEFITS WILL BE IMPLEMENTED OVER A 40 YEAR PERIOD. HOWEVER, THE COUNCIL BELIEVES THAT TO CONTINUE TO HAVE A VIABLE MEDICARE PROGRAM MORE IMMEDIATE CHANGES IN THE AGE OF ELIGIBILITY FOR MEDICARE ARE NECESSARY.

FINALLY, THE COUNCIL ENDORSES THE CONCEPT OF "ADVANCE DIRECTIVES" OR "LIVING WILLS" WHICH ARE CURRENTLY RECOGNIZED BY LAW IN FOURTEEN STATES. THE COUNCIL CALLED FOR A STUDY TO LOOK AT THE IMPACT ON HEALTH EXPENDITURES IN THOSE STATES HAVING SUCH LAWS AND ENCOURAGED OTHER STATES TO ADOPT SIMILAR LEGISLATION. LIVING WILLS WOULD PREVENT UNNECESSARILY HEROIC MEASURES BEING TAKEN IN THE TERMINAL DAYS OF LIFE. ELEVEN PERCENT OF MEDICARE EXPENDITURES ARE SPENT IN THE LAST FORTY DAYS OF LIFE AND SOME 25 PERCENT OF MEDICARE EXPENDITURES ARE INCURRED BY PATIENTS IN THE LAST YEAR OF LIFE. THE COUNCIL FULLY RECOGNIZES THAT THIS MAY BE A CONTROVERSIAL RECOMMENDATION; HOWEVER, THE COUNCIL UNANIMOUSLY ENDORSED IT. AS A PHYSICIAN, I INITIATED COUNCIL DISCUSSIONS ON THIS SUBJECT HAVING RECENTLY LOST MY FATHER AND THUS KNOWING THE ENORMOUS COSTS THAT WERE INCURRED IN HIS TERMINAL DAYS PRIOR TO DEATH.

THE COUNCIL RECOMMENDATIONS I HAVE JUST REVIEWED WOULD, IF ENACTED, ELIMINATE THE FINANCIAL BURDEN ON THE HOSPITAL INSURANCE TRUST FUND. IF THOSE RECOMMENDATIONS WHOSE SAVINGS OR REVENUES HAVE BEEN QUANTIFIED WERE TO BE IMPLEMENTED PROMPTLY, THE TRUST FUND WOULD BE FULLY SOLVENT IN 1995 WITH A MODERATE RESERVE TO GUARD AGAINST CONTINGENCIES. THOSE RECOMMENDATIONS WHICH HAVE NOT BEEN QUANTIFIED REPRESENT, IN OUR VIEW, VIABLE ALTERNATIVE SOURCES OF REVENUE IN THE EVENT OF DELAYS OR FAILURE TO ADOPT PORTIONS OF THE QUANTIFIED PACKAGE.

MR. CHAIRMAN, THAT COVERS THE HIGHLIGHTS OF THE MORE SIGNIFICANT RECOMMENDATIONS OF THE COUNCIL. AS YOU ARE AWARE THERE ARE ALSO SEVERAL OTHERS WHICH I WILL BE HAPPY TO DISCUSS WITH YOU.

I DO WISH TO NOTE THAT IN ADDITION TO OUR FORMAL RECOMMENDATIONS THE COUNCIL DID IDENTIFY SEVERAL ISSUES WHICH THEY VIEWED AS DESERVING OF FURTHER STUDY BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. THESE ARE SPELLED OUT IN THE COUNCIL REPORT AND INCLUDE SOME SUGGESTED ALTERNATIVES FOR A LONGER TERM RESTRUCTURING OF THE MEDICARE PROGRAM.

I WOULD NOW BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator PACKWOOD. Doctor, just two or three questions On page 10, you make reference to the taxation of the health insurance premiums. That proposal has been commonly recommended by the administration and strongly opposed by a fair number of us, including myself. If I read your statement correctly, you are not looking at that from a revenue standpoint, but as a hoped-for discouragement of overutilization of services.

Dr. BOWEN. Yes, that is right, and I believe that our recommendations stated that health insurance expenditures beyond the $175 a month for a family, or $70 a month for an individual, the amount above that would be taxable as income. Now, it is felt that this would help to change the patterns of use of medical care. In other words, it would sort of get away from the first dollar coverage on everything, which is one of the things that does tend to run the costs of medicare up.

Senator PACKWOOD. Are you presuming that you will have—let's take the $175 figure—and that is all you will have in benefits and therefore you are going to have to cut out some benefits? Or are you presuming that it will continue in many cases to be over that amount and that the employee will have to pay taxes on it? What then? Insist upon what—try to get benefits down to $175 so it is not taxable? I am not quite sure I follow the thinking.

Dr. BOWEN. That would be an item, it seems to me, that would be bargainable between management and labor on how high they go and what they do.

Senator PACKWOOD. This is what I am curious about. Is the presumption in the report that indeed we are not going to collect any more—what is going to happen is that the bargained-for premium will end at where taxation starts, and if in order to end it at $175, you have got to eliminate some benefits, that is what will happen?

Dr. BOWEN. That undoubtedly would be what would happen? yes.

Senator PACKWOOD. I mean, that is the presumption. I am not sure if that is what is going to happen, or whether you are going to actually have an employee who, at the end of the year, discovers they have got another $75 a month in health premiums, adding up to $900 a year upon which they pay taxes. I am not sure the automatic result is that you are not going just cut off benefits at $175. Did the Commission have any evidence one way or another as to what may be the reaction. The reason I ask you is that I haven't found any evidence from anybody else, one way or the other, as to what they think is going to happen.

Dr. BOWEN. It would just be a guess. Dr. Rahn might have an answer on that, with his background. He may know more about that than I.

Senator PACKWOOD. Go ahead, sir.

Dr. RAHN. I am also vice president and chief economist of the chamber of commerce, and we have opposed this particular recommendation, and I had voted against it. And much of our concern was that this is starting to get into the taxation of fringe benefits, and that is something, of course, that Congress has been struggling with as we have in the business community for quite some time, without really looking at the total ramifications of this. We have at this point little evidence about what extent behavior would be altered in either way, but we felt it was premature to get into the

issue without perhaps further study to basically answer the questions that you have just addressed.

Senator PACKWOOD. That has been my experience. I haven't found any evidence one way or the other, as to what might happen, but I would be surprised if a plan that now costs $225 a month would be cut to $175 a month simply because that is where the level of tax is started. It is just that my intuitive hunch tells me that collective bargaining doesn't work that way.

Dr. RAHN. There would certainly be some cases like that and some cases with no change at all, but we really don't know. And this is something we feel that we ought to look at much more carefully.

Dr. BOWEN. I think that there would be a slow change, to say the least. However, it is estimated that there would be about a $7 billion increase in social security HI taxes accumulated between 1985 and 1995.

Senator PACKWOOD. That is an argument we have had with the Treasury Department for a long period of time, as to their revenue projections on this. Treasury has to presume that the benefits are not going to be cut, and there is going to be taxable income or else there is no revenue. That is not an assumption that is uniformly accepted.

Mr. RAHN. This is the constant problem with Treasury projections of revenues coming from tax increases. They always use a static view of the world, and overlook altering behavior. Now, we know behavior is altered. We just don't know the degree to which it is.

Senator PACKWOOD. The classic example of this—although it is unrelated—is where we have seen the taxation of capital gains. I remember when Treasury testified when we cut the tax on capital gains that the revenues would drop, and you would say to them, but Mr. Secretary, maybe more people will buy and sell stock, in which case the revenue might increase. It turns out that, indeed, Treasury was wrong. With the drop of the capital gains tax, more people did buy and sell stock, and the revenues have held value, and there has been no revenue loss.

Let me ask you a second question, Doctor. The Council—and I am reading from your unanimous recommendation—"Some studies have shown that targetting the population offered home care services as an alternative to institutionalization is a more efficient and appropriate way to deliver care. The Advisory Council on Social Security suggests that, in developing a comprehensive long-term care program, the Secretary of Health and Human Services be guide by the results of these studies."

I think we have seen enough studies now to know that, if you could trade one for one, you are going to save money. If somebody who is hospitalized but doesn't have to be could have home health care, you will save money. The fear that we have expressed, time after time after time, is the utilization of home health care services by people who now are not covered or who don't, for whatever reason, utilize hospital services. Did the Council address itself to that and consider it?

Dr. BOWEN. We talked about, but we just didn't have the time to go into that in detail. We had about 13 months really, and that is a pretty short time.

Senator PACKWOOD. You have done a stupendous job in a relatively short period of time, and I congratulate you on the comprehensiveness of the report.

Dr. BOWEN. We do feel that preventive care is probably one of the most important areas to help hold down the costs, but that method of implementation would have to be studied.

Senator PACKWOOD. My own State of Oregon has some very good, although limited, experience. They have been for the past 2 years taking people, namely elderly welfare cases, that would otherwise hospitalized and finding a way to care from them in some cases—foster home care in their own homes—which has very significantly cut costs. If they can accurately count it individual by individual, they are talking about a carefully monitored experiment saving about 100 million a month. In each case, the person that was receiving the home health care would have been otherwise be hospitalized. Given that circumstance, you are going to save money. But even Oregon wondered if they could keep the same kind of quality control if you are talking about everybody that was going to be hospitalized who might otherwise get home health care—or to put it the other way around—everybody who might be eligible for home health care who at the moment doesn't get it and also is not hospitalized.

Dr. BOWEN. I think there are two dangers, one of which you have mentioned here, and that is maintenance. The quality of care if they get out of the hospital too soon to get the home care, which may not be as good. I think there is another. I have no quarrel with what is going on, but I think there are companies springing up rapidly now for home health care, and will the home visits be frequent enough and the expense be enough that you are going to lose the gain that you otherwise might be expecting.

Senator PACKWOOD. A third question. You recommend raising the retirement for medicare from 65 to 67 over the next 5 years, which is a relatively rapid change. Are you presuming—just in that 5-year period—that employers will pick up the cost on insurance for that 2-year period even though you are retired? Are you presuming that people will work longer because they now cannot be mandatorily required to retire? Are you assuming that they will all self-insure for that 2-year period? And what was the Council's assumption?

Dr. BOWEN. That is one of the biggest problems that we faced in that particular recommendation, as you well know. I think that we ended up stating that this should be a requirement of future and more intensive study. That is a big problem. They feel that they probably should be able to work longer instead of being forced to retire.

Senator PACKWOOD. Of course, under the present law, they can be allowed to work longer. Our experience again has been that most people—now most people—I am not talking about some people—most people don't want to work longer. So, even though we have changed the compulsory retirement provisions, most people are not working to the limit that the law would allow.

Dr. BOWEN. There is another point on that. Those people wouldn't be much different from those retiring at the age of 62 now.

Senator PACKWOOD. That is interesting. In some cases now, you have with employers some carriage of coverage between 62 and 65, not the full coverage that they had when they were working, but some. It is an unusual plan, and there are some, but a very unusual plan that carries people beyond 65, and that is when the mandatory retirement age of the company used to be before the change of the law.

Senator DURENBERGER. I was holding back jumping into the cap argument, but do you, Mr. Chairman, have a present plan to start the hearings on fringe benefit taxation?

Senator PACKWOOD. I will respond to that in just a second. Doctor, I would like to submit to you if I could some questions from Senator Bentsen. Almost all of them are related to catastrophic insurance, and he simply asks if you could respond in writing for the record.

Dr. BOWEN. I will be happy to do that.

Senator PACKWOOD. Dave, we have not yet set a date. I was hoping we would get the tax bill out of the way first and get the matters I have got in the Commerce Committee out of the way first. Those are things that Howard Baker said you have got to get done before we move onto things that we don't have to get done.

Senator DURENBERGER. Perhaps by late spring?

Senator PACKWOOD. I don't know. I just haven't set a date, but they will be held in this committee.

Senator DURENBERGER. Late summer? [Laughter.]

Senator PACKWOOD. 1986.

Senator DURENBERGER. Oh, that is not the answer I was looking for. [Laughter.]

Senator PACKWOOD. We will have hearings this year. I am assuming, very frankly, that based on what we have done in the Tax Committee of the Finance Committee and in Ways and Means, that we are not going to have another serious effort at the taxation of fringe benefits this year. However, rather extensive hearings will be held this year, so we have some kind of a record when we start next year. The reason I assume we need the record is that, unless I miss my guess, the President is going to be recommending some significant revenue increases after the election.

Senator DURENBERGER. Right. Thank you. I appreciate that. I indicated in my opening remarks, Governor, that I don't think DRGs are the end all, and the reason I don't is that there is a fairly important part of the DRG system that has been left out, and that is the fact that there aren't any rewards for the patient in the system. There are rewards for efficient hospitals in this episodic approach, but there are no rewards for the individual. In fact, the first few thousand we have heard from think they are being penalized because they are being sent out of the hospital too early, but they don't perceive that there are any financial rewards for them as patients. And that leads me to my deep concern—that I have shared with the Commission in my testimony—about your restructuring proposal. As you indicated in your testimony, the part I agree with is where you have introduced coinsurance into part A,

at 3 percent, and now they have got a bill that says 6 percent, but some small amount of coinsurance per hospital day seems to be appropriate. Now, I don't know what your rationale was for the appropriateness of that. It may be that it made some money. My rationale for it is that it introduces an incentive on the part of the person going into the hospital to consider whether or not they ought to stay a couple, or 3, or 4, or 5 extra days.

And so, it becomes very important to me that persons have some incentive for making decisions about whether they are going into the hospital. We now have a disincentive in the form of a deductible—and you appropriately set a preadmission deductible—I will compliment you on that—and then add this daily coinsurance which I approve of.

But then, you come along with this proposal in part B which, in effect, just wipes out what you did in part A. If I understand your part B proposal, everybody who elects part B—and about 95 percent of the people do today—would get this expanded coverage. So, you leave me looking at your recommendations saying, yes, we have part A coinsurance, but then over in the part B side, we have a proposal that wipes it out because you can, in effect, get it for free. The second part is that you have a premium that, as I understand it, you set at just a little bit higher than the anticipated cost. I take it that makes you some money in the beginning, but if you will recall, back in 1965 or 1966, when our predecessors put this whole program into effect, they too started with a premium to cover at least 50 percent of the cost of part B.

That one is down now to 25 percent because people around this table over the years have just let that thing slide. In fact, this year when we tried to move it back up, people on both sides—this is a nonpartisan issue—of the aisle said, oh, you can't do that. So, I am troubled from that standpoint as well, that you may set us up in effect with another Government insurance program with a premium that you think is going to make money, but the historical performance of the Congress is to let that baby slide. It seems like it is going to end up costing us money. It seems to me that you got where you got because you bought the theory that a lot of senior groups have been trying to sell us. You want catastrophic coverage, and that is very, very appropriate. We should have had it in there in 1965. We are somehow going to get catastrophic. But the senior groups have been telling all of us that there are only a few folks that have catastrophic needs—those that stay in longer than 60 days. Why should all of the many more folks who stay in less than 60 days pay for those people? First, your response was to go over to part B, and I think on page 6, you say that then a substantial majority of the beneficiaries will then be paying for this catastrophic protection.

Now, I buy that same theory—that a substantial number of the beneficiaries ought to pay for catastrophic coverage, but I do it by going back and remembering that 70 to 75 percent of the people are also buying medigap insurance. Today, if I am a medigap insurer, I have no incentives to try to save premium money for people on the hospital side because the first 60 days are free. The first day costs you something, but 2 through 60 is absolutely free.

So, if I wanted to come into the medigap insurance business and really be efficient—leverage those providers and offer better premiums and competition with other medigap insurers—there is nothing on the hospital side that provides incentives. Now, the value of having coinsurance in there is to get more efficiency out of the medigap insurance program, through competition, that would reduce the cost of the medigap premiums for 75 percent of the people. So, I accomplish the same thing, that your program accomplishes, and I don't have to do it by wiping out the utilization impact of coinsurance.

Now, I know I came to the Commission late in the process with this alternative, and I am curious to know whether you have had any chance to look at both sides of the issue and analyze the medigap market to see whether my theory was correct or not.

Dr. BOWEN. Those are probably some of our most painful types of decisions and discussions. Yes, we did go into all of that. We felt part A in our present plan would help to curb overutilization and that the part B actually is optional even though actually most of the people take it, but they still aren't forced to take that other part of the insurance program. And the part B with the increased premium—yes, the cost to cover the increased costs, I believe, we have added $46 to the premium, and we added $42 of increased income to help make up the deficit. Then the last part is that, I guess, we have to have faith that Congress will not let happen what has happened in the past.

Senator DURENBERGER. I don't quite understand which is optional. You have a part B program that covers the coinsurance on part A, and you have a part B program that provides catastrophic in part B. I thought it was the latter that was optional. Is that correct?

Dr. BOWEN. It is optional, yes.

Senator DURENBERGER. OK, under your proposal folks would be paying an additional premium when they elected part B, but then there is no option as to whether or not you would take the wipeout on part B coinsurance.

Dr. BOWEN. Part B itself is optional.

Senator DURENBERGER. Yes, it always has been. So, when you take part B under your proposal, you get the coverage for your coinsurance on part A.

Dr. BOWEN. That is right.

Senator DURENBERGER. And 95 percent of the folks are now exercising the option to take part B so, presumably, 95 percent of the people will be glad to wipe out their coinsurance on part A.

Dr. BOWEN. Yes. That is what insurance in all about, I believe.

Senator DURENBERGER. I will get to that in a second. But the second part on part B then is optional. Now, what can you tell me about who would make that particular option, in other words to get a catastrophic on part B? It seems to me that, the way folks usually operate, the people that really think they are going to need that catastrophic—those that are already not feeling well or whatever—are going to be the first ones to exercise the option to pay the $227 or whatever it is to get that catastrophic, and those are the sickest of the people, and so you are going to get a whale of a lot of adverse selection.

Dr. BOWEN. I don't know. It seems to me that at the age of 65 you can't be that certain whether you are going to be in good health the next day or not, so I am not sure your argument would hold there.

Senator DURENBERGER. But you acknowledge that the potential for adverse selection is there?

Dr. BOWEN. Certainly, there is. Mr. Burke has a comment.

Mr. BURKE. The figures that were quoted in the testimony for part B assumed that there would be a large participation. To that extent, they are reasonably soft numbers. If you did get extensive changes in participation, the premium numbers would not hold. On the other hand, it is not realistic to assume that at the proposed rates adverse selection would occur. The current percentages that are buying medigap, even though they may not be high risk health users, would be attracted to the optional part B since probably—due to the marketing and other costs which would not be inherent in the premium—it would be a better bargain for them.

Senator DURENBERGER. The next question is regarding your position on income testing of the Medicare Program. I understand you oppose income testing in the Medicare Program. Is that correct?

Dr. BOWEN. Yes. We rejected that.

Senator DURENBERGER. You know, of course, that today under part A, out of the trust fund everyone in medicare is getting about $1,700 per year. And the cost of the current program for all 29 million people is about $1,700 per year, so that everybody—rich, poor, whatever—is already seeing a contribution of $1,700 out of the part A trust fund. Part B is financed from general revenue, and I know there are a lot of folks who say that it is the same thing—I am just as entitled to general revenues since I have paid income taxes all my life as I am to part A where I paid a payroll tax. But your opposition, in effect, means that you and I and 100-plus million other taxpayers in this country are going to continue to subsidize those part B premiums for the millionaires in this country and a whole lot of other folks to the tune of about this year $550 per year per person. I just wonder if there is a Commission rationale as to why those who can afford to pay more for their insurance should not be asked to pay closer to 100 percent of the actual part B program costs.

Dr. BOWEN. I have just two comments on that, and the others can state their own views on it. But I think it was probably the philosophy of Government that the majority had, and that is that if you wanted to make it a welfare program totally, it should be of two programs. The second was the fact that the self-employed now are paying—or will be by 1990—14 percent of their first $57,000 that they make into the program. So, that is a sizable chunk over and above all other taxes that they pay. It is a question then of how much subsidization are you going to continue.

Senator DURENBERGER. But they are getting out $1,700 from the trust fund this year, next year probably $19, then $21, and $23, and we have to give them, on an equitable basis, part B because we are already paying in for part A. That must go with the welfare part of your statement.

Dr. BOWEN. There is a limit on the number of years they get that back. I am not familiar with that.

Senator DURENBERGER. Let me go to another subject. In your statement it is indicated that two Senators, one of whom is on this committee, had something to say about alcohol taxes, and unfortunately, you went on to say that it had negative effects on the industry. I just wanted to go on the record as the one person who testified on this committee that I said nothing about the negative effects on the industries involved. They can struggle for themselves.

But one of the points that I made—and I think this is probably a very crucial part of our debate—if Bob Packwood were here, we could discuss it in greater length because he is a great champion of what you would call unisex insurance—is that the problem with dedicated excise taxes is that there always has to be some kind of a tie to the use of the product to the Federal program. It has struck me that we ought to be trying to make these connections but not through excise taxes.

If we could fold these costs—the health costs—into the premiums that people pay for their health insurance it seems to me that we might have a greater impact on their behavior. In my State, Minnesota Blue Cross is offering up to a 22 percent discount for nonsmokers, and there are a whole lot of other insurers moving in that same direction. It seems to me, given the fact that to a degree we are dealing in habits when we talk about alcohol and tobacco, and we are dealing to a degree with economic problems as we add taxes. It might be preferable if we concentrated our efforts at the insurance premium level to distinguish between good habits and bad habits. I told you my other problem was that then we have to go to automobiles and motorcyclists who don't wear helmets and sugar and salt and a whole bunch of other things. But whether or not there was an opportunity to debate the subject and whether or not we might be aiming our efforts at insurance as opposed to taxes rather than behaviors.

Dr. BOWEN. There was very little debate on that particular issue, but how about enforcing it? How certain are you that the application that says I do not smoke, I do not drink—how are you going to enforce that? Can you be certain that that is a truthful statement on the form?

Senator DURENBERGER. I don't know. That is a problem that the insurance industry comes in and tells us about when they talk about unisex insurance and all that sort of thing. It strikes me that somehow the talent that lies out there in the insurance industry is going to figure out a way to handle some of those problems.

Dr. RAHN. I would like to add just one thing to that. I was a skeptic about the increase in taxation because I had argued that Congress is likely to increase those taxes but not designate those to medicare, and I just note that the tax bills that just came out of your committee and of the House have an increase in alcohol and tobacco taxes but not a provision where it would be applied to the medicare trust fund.

Senator DURENBERGER. It was alcohol and not tobacco because we have some Republican Senators up in tobacco States, so we only did alcohol, and again we made it much more difficult for States all over this country to use alcohol excise taxes as a way to fund their own programs at the State level, and of course, we are sending a

lot of responsibility back there, some in the health area and some in other areas.

Dr. BOWEN. Yes, there are good arguments on the side that you are on. I think there are good arguments on the other side, too, and as I say, were I still Governor, I probably would be on your side on the fact that you shouldn't utilize alcohol and tobacco taxes for this purpose. However, we sort of considered it as a user's type tax because studies have nailed tobacco and alcohol use and abuse time after time as being causes for increased utilization of medical care and increased hospitalization. So, you do have some justification there. However, we recognize that motorcycles, and butter and sugar and salt, and these other things might be, too, but again alcohol and tobacco probably would be the least objectionable of all of those. And when you are faced with the fact that you have been charged to come up with $200 to $300 billion, you look where the money is, and that is essentially what we are trying to do.

Senator DURENBERGER. I am getting to the end of my questions, but Bob Packwood was asking about changing the age from 65 to 67. Did you have any time to look at sort of a related problem, which is—and it has sort of been bothering me but I just haven't had any time to get into it—and that is that ages are always arbitrary, and if you adopt any theory—the longer you live, the longer you work—the further out we can extend the period—that is one thing. But it seems to me the reality is that there are a lot of people today under 65 that lack insurance coverage, and I think first of widows, people who somewhere after 55 find it very difficult to find employment—or they come out of self-employment or some other area in which there is not a continuity of health coverage—and that somehow, as we are playing with these dates, we might also look at the fact that even going back from 65 there might be a population out there that might benefit from medicare. Did you have a chance to look at that issue at all?

Dr. BOWEN. We did not go into any detail on that, but we did discuss it some, and the very fact that you set the age at 65 or at 60 or 55 means that there is always going to be a group for whom there will have to be exceptions. And of course, you have to be very cautious to make sure that they are also taken care of in some way or other. But we are also faced with the fact—and we could give you just a few figures on the aged—that there are 30 million on medicare now, and there will be 60 million by the year 2020, which is not that far off. And between those years, in the 50-year period between 1980 and 2030, there will be an 80-percent increase of those between the ages of 65 and 74. There will be a 220-percent increase between 75 and 84, and there will be a 280-percent increase of those over the age of 85. But the problem doesn't end there. It is a fact that the older you get, the more care you need and the more expensive the care. The figures show that between the ages of 65 and 69 in 1981, the average cost was $1,490 and then for those above the age of 85, the cost was $2,247. So with the increased cost with the increasing numbers, it kind of complicates the problem that you face. And I don't envy your problem here.

Senator DURENBERGER. The last question. Did the Council recommend that we not extend medicare to new disease treatment?

Dr. BOWEN. Yes, we did. Not that we are opposed to it, but there are some 80,000 people who are on kidney dialysis that are on medicare, irrespective of their age, and this runs into a few billion dollars, and we are not opposed to helping those individuals, but we feel that it is coming out of the wrong pocket when it is placed in medicare. That is one of our recommendations that we do not extend the medicare by diagnosis.

Senator DURENBERGER. Do you have an opinion, as a former Governor, on Dick Lamm's comments on the terminally ill elderly?

[Laughter.]

Dr. BOWEN. Well, he said it wrong.

Senator DURENBERGER. You mean there is a point there somewhere, but he just didn't articulate it correctly?

Dr. BOWEN. That is a very touchy subject, and we did touch on the living wills—as you know—and the reason being that 30 percent of all medicare expenditures in any year is for those in their last year of life. Eleven percent of the $60 billion that will be spent this year will be spent on those in the last 40 days of life. And as a physician, and I think as an observer of the program that there are many, many thousands of those individuals who don't want all of this done to them. They are heroic types of treatment that are very expensive, and knowing full well that it is not going to be effective. It is tough to talk about because you immediately get accused of talking about euthanasia and this type of thing. And that is the furthest from our thoughts. We want it to be totally voluntary and we want to encourage the use of living wills so that people in this age group can make their own choices, but totally voluntary, and if there is any question, it should be with consultation with the physician or the minister and the family—anybody that can be involved before any such decision is made.

Senator DURENBERGER. All right. Thank you very much. Does anybody have any questions? The chairman of the committee, Senator Dole, will have questions that we would appreciate your responding to.

I thank you all very much and all of our other witnesses. The hearing is adjourned

[The questions of Senators Dole and Bentsen and answers from Dr. Bowen follow:]

ADVISORY COUNCIL ON SOCIAL SECURITY

200 INDEPENDENCE AVE., S.W.
WASHINGTON, D.C. 20201

Otis R. Bowen, M.D.
Chairperson

Thomas R. Burke
Executive Director

MAY 10 1984

The Honorable Robert Dole
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In response to your letter of April 11 I am pleased to provide you with the following answers to your questions.

1. The Council recommends a 3-percent coinsurance on hospital days. How does current coinsurance applied in Medicare compare with coinsurance paid in the better plans for employed groups?

   Current provisions of the Medicare program require no coinsurance from the 2nd thru the 60th day of inpatient care. From the 61st thru the 90th day the coinsurance is equal to 25% of the inpatient deductible (currently $356.00) or $89 per day and for the 91st thru the 150th day the coinsurance is equal to 50% of the deductible or $178.00 per day. After 150 days of inpatient care in a benefit period the beneficiary is liable for all inpatient expenses.

   Considering the substantial coinsurance applicable after the initial 60 days of inpatient care and the potential for exhaustion of coverage after use of the 60 lifetime reserve days, Medicare does not provide comprehensive catastrophic coverage.

   In comparison, most of the better group health insurance plans offered to employee groups provide unlimited inpatient days per year without coinsurance.

   The Council's recommendation would insure all beneficiaries received unlimited inpatient days of care. The cost of this extended protection is covered by a level 3% coinsurance on all days of care used with payment of an annual premium eliminating this coinsurance cost.

2. In examining the range of services Medicare provides, the Council recommended consideration of preventive services. In this context, did you consider expanding the availability of mental health services? In this same context did you consider expanding the providers eligible to participate? For example, recognition of psychologists?

Although the Council did discuss preventive services, and while it did hear testimony from such organizations as the National Mental Health Association, and the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging, it did not address mental health services, per se. Rather, the Council focused on preventive services that would identify physical disorders, and recommended that the Health Care Financing Administration undertake a comprehensive review of its demonstration projects to assess the economy and efficiency of including them under Medicare. Basically, the Council believed that faced with a deficit of staggering proportions the Medicare program could not support expansion of coverage, scope of services or types of providers at this time.

3. I recognize that the Council considered and rejected means testing entitlement to the program. Did the Council consider any mechanisms which would link cost sharing or premium payments to an individual's income or wealth?

   The concept of means testing via differential cost sharing or premium payment levels linked to income was considered to some extent in the "Issues Deserving Further Study" section of the Report. The two versions of IRAs that are outlined in that section have income related mechanisms incorporated in them.

   The Council considered a low income adjusted premium for the enhanced Part B premium, however, this option was subsequently discarded in favor of an alternative optional Part B proposal. The Parts A and B premium proposals endorsed by the Council are certainly amenable to income or wealth adjustments. The Council did not incorporate such adjustments because the premium to finance the enhanced Part A was sufficiently small as to not warrant such adjustments and the Part B premium proposal was made voluntary.

4. The Council recommends the use of fee schedules to control costs. How would the fee schedules be set so as to assure that they would not be subject to the same problems as the present system from rising use of services, unbundling, new services, etc.?

   Any physician reimbursement scheme short of a capitation-based system is severely limited in its capacity to restrain increases in utilization. Two points need to be made with respect to the Council's recommendations in the area of physician reimbursement. First, the Council's recommendations were not intended to reduce program expenditures. Rather they were intended to correct certain, though not all, deficiencies in

the present system. Utilization restraints to better cope with new services, unbundling and overall increases in services provided were addressed by the Council to the extent they encouraged alternative reimbursement systems which were noted by the Council as being "... proven cost effective."

Finally, it should be noted that the Council operated under the assumption that the vast majority of physicians would comply with professional ethics in the conduct of their business. It cannot be assumed, nor should national policy be formulated on the proposition that the majority of physicians will "game" the system so as to maximize their reimbursement.

5. The Council recommends an increased premium be paid by beneficiaries to eliminate some of the coinsurance. Is there a problem that many aged would find the cost a serious burden?

   The Council members wished to assure that any required additional premium not place a serious burden on beneficiaries. The estimated premiums for the Part A improvements ($98 in 1985), in the Council's view, should not prove burdensome for the substantial majority of beneficiaries. Those at very low income levels are typically covered by Medicaid and we expect the various State Medicaid programs will pay this additional premium under buy-in arrangements they now utilize to pay the Part B SMI premium.

   The enhanced Part B protection plan recommended by the Council was made optional primarily because its additional estimated cost ($150 in 1985) could prove burdensome and unaffordable to some beneficiaries at income levels that may be high enough to preclude Medicaid eligibility yet still low enough to result in an increase in premium of this magnitude being unaffordable.

   When considering the additional premiums proposed for both the Part A and the Part B enhancements, the Council was impressed by the fact that at least 70% of the Medicare population now purchase private Medigap insurance to cover gaps in Medicare and the premiums they pay are generally higher than those proposed for the Council's restructure plan.

6. Raising the age of eligibility to 67 raises the question of whether private health insurance coverage of the substantial number of persons 65 or 66 who are not employed would be adequate and reasonable in cost. There is even an issue about whether group contracts would necessarily be extended to those who are 65 or 66. Nevertheless, what view do you take of limiting this change to persons employed where group health insurance is available and requiring that all group coverage, including self-insured plans, extend to the age of eligibility for Medicare?

The Council discussed at some length what has come to be known as working aged proposals. Although the members did not make a specific recommendation in this area they did identify it as an area deserving further study.

I believe the Council would not have been favorably disposed to limiting the increase in the age of eligibility to employed persons with group health coverages available. While the Council did favor Medicare not being the primary payor in cases where other health insurance coverage is available, they, nonetheless, believed that good and sufficient rationale existed for recommending that the age of eligibility for all Medicare beneficiaries should be increased from 65 to 67. Some of the more persuasive arguments supporting this position included the increased life expectancy experienced since the inception of the Social Security program, as well as the forecasts regarding the numbers of persons that will be paying into the program for each beneficiary collecting from the program (projected to be 2:1 by the year 2000).

These above considerations, coupled with the sizeable Medicare program savings associated with this recommendation, prompted its strong support by the Council.

Finally, the arguments that this change would leave large segments of population without health insurance was not thought to be significantly different for persons retiring at age 66 than for persons who currently retire at age 62 or 63.

If you have any further questions please do not hesitate to let me know.

Sincerely,

Otis R. Bowen, M.D.

cc:
Chief Clerk Senate Finance Committee

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Executive Director

APR 27

Honorable Lloyd M. Bentsen
United States Senate
Washington, D.C. 20510

Dear Senator Bentsen:

This is in response to the written questions you submitted at the April 9, 1984 hearing of the Senate Finance Committee. I am in full agreement with your position that although only a limited number of Medicare beneficiaries experience illnesses that result in the exhaustion of lifetime reserve days under Medicare the potential for such a financial catastrophe is of great concern to all beneficiaries. The fact that a substantial number of them now purchase private insurance to protect against such a possibility is evidence of that concern.

The benefit restructure plan recommended by the Advisory Council satisfies the objective of providing catastrophic protection to all beneficiaries in a manner that assures an equitable distribution of the added costs of this protection, while at the same time contributes to the resolution of the serious financial problems of the Part A trust fund.

Answers to your specific questions follow:

1. What exactly does the Council mean by catastrophic coverage? and who would qualify for that protection?

   By catastrophic coverage the Council meant the potential for substantial financial liability resulting either from significant coinsurance requirements or exhaustion of coverage that Medicare beneficiaries can face in the event of a serious illness requiring frequent and/or long term hospitalization. The Council focused on hospital inpatient care coverage provided under Part A of Medicare although in their final recommendation they also addressed the issue of limits of financial liability for medical services provided under Supplementary Medical Insurance, Part B of Medicare.

   With respect to Part A of Medicare, the Council's objectives were to restructure the current benefit package to provide unlimited days of inpatient hospital care, simplify the benefit

by eliminating the benefit period "spell of illness" concept and insure that cost sharing by beneficiaries was equitably distributed and reasonable. All persons eligible for Part A under current rules would qualify for the improved protection.

2. Should catastrophic coverage be voluntary or mandatory? If voluntary, as I think your report suggests, who could be left out and why? What would the premiums have to be if such coverage were voluntary as opposed to mandatory?

The Council considered a completely mandatory premium approach which would make the Part A hospital insurance benefit of Medicare contingent on the payment of a monthly premium in addition to payroll tax contributions during one's working years. Failure to pay the premium under this approach would result in termination of Part A coverage. The Council viewed this as an unacceptable alternative since beneficiaries could lose their basic Medicare hospital insurance protection even though they had made trust fund contributions over their lifetime.

A totally separate voluntary program, e.g., an approach that would offer a basic Medicare Part A benefit similar to the current benefit based on payroll contributions and an optional catastrophic supplement for a separate premium payment, introduced the distinct possibility of adverse selection. If voluntary, the added protection might, to a significant extent, be selected by beneficiaries in poorer health with a higher probability that they would need the catastrophic benefit protection. Premiums would be less predictable and could become very costly, further eroding the availability of the protection to all beneficiaries.

To insure adequate catastrophic protection at a reasonable cost, it was considered essential that the substantial majority of all Medicare beneficiaries be enrolled in the plan.

The Council's recommendation provides for a restructured Part A benefit, available to all who meet basic eligibility requirements. The basic plan includes catastrophic protection but requires a 3% daily coinsurance on all inpatient days not subject to a deductible. The 3% coinsurance covers the cost of the improved protection and reduces program expenditures. (It must be noted that the Council was also addressing the serious financial problems confronting the Part A trust fund.) The Council recommends that an enhanced Part A package that would cover this 3% coinsurance plus the 12.5% coinsurance imposed for skilled nursing facility days, be offered as an integral part of

the Part B SMI benefit. Though voluntary, more than 95% of the Medicare population elect Part B coverage and thus we expect a substantial percentage of the population would opt to be included in the Part A enhanced benefit program. With a high participation rate the annual premium to cover these coinsurance costs is predictable and reasonable. The estimated cost would be $56.50 per year in 1985. The Council also recommended increasing this premium by $42.00 per year for total premium of $98.50 in 1985. The additional $42 would be to increase revenues critically needed by the HI trust fund.

3. How many individuals fail to opt for the Part B today? Why? Shouldn't these 1.4 million also have catastrophic protection? Wouldn't it be to the Federal Government's advantage to extend such protection when it is less costly than to pay for the health care when the individual exhausts his or her coverage and must turn to Medicaid?

   About 4.6% of those eligible for Medicare based on the disability provisions and somewhat in excess of 2% of the aged elect not to take Part B coverage. While the reasons are unknown in some cases, it is known that many of these are veterans who consider their veterans medical benefit as adequate to meet their needs, while others have a working spouse with group insurance that covers them. I agree that those who do not elect Part B should also have Part A catastrophic protection. The Council's restructure of the basic Part A plan provides that catastrophic protection to all, although for those who do not take Part B the daily coinsurance would apply. Although the Council did not investigate the details of offering the premium-financed Part A enhancement that covers coinsurance to individuals who do not have Part B coverage, that would seem to be a feasible option.

   Most Medicaid eligibles are covered for Part B through the State buy-in provision of the law. We expect that States would find the additional premium cost for the Part A improvements to be cost effective and thus would continue to buy-in for their Medicaid eligibles.

4. Will the approach you advocate (providing catastrophic protection plus an option to obtain Part B coverage for hospital and nursing home coinsurance) do away with the need for private sector so-called "Medigap" insurance?

   We believe the Council's recommendation would certainly reduce, and for many eliminate, the need for "Medigap" insurance of the type now marketed by private insurors. Certainly some beneficiaries may desire to purchase insurance covering the inpatient deductibles

that are retained in our Part A restructure plan and Medigap insurors may also offer additional benefits not covered by Medicare, e.g., outpatient drugs, extended SNF days, etc.

5. Finally, would you support the addition of a premium financed catastrophic provision to Medicare in the absence of other changes in the program? (Changes such as the 3% and 12.5% coinsurance and the limit on tax free employer contributions to health protection for employees?)

Speaking for myself as Chairperson of the Council, (I cannot speak for the other members since the options you present were not considered by the full Council) I could support a premium-financed catastrophic provision to the Medicare program.

A premium-financed catastrophic feature was considered by the Council to be preferable to a coinsurance-financed catastrophic feature. The latter was viewed by the Council as a form of user tax or a tax on sickness whereas the former was considered more consistent with accepted insurance principles of spreading the risks among all enrollees.

However, I would not recommend such a stand-alone change since such a change, in and of itself, would do little to rescue the financially burdened Medicare Program. A catastrophic component incorporated into a fiscally bankrupt program would appear to have little merit.

Again, I wish to emphasize that as part of the Council's efforts to improve the overall Part A benefit offered the Medicare population we were also endeavoring to reduce to some extent the current wide disparity between tax contributions and benefit payout in the Part A trust fund.

If I can be of further assistance in clarifying the Advisory Council recommendations, please let me know.

Sincerely,

Otis R. Bowen, M.D.
Chairperson

cc:
Chief Clerk
Senate Finance Committee

[Whereupon, at 11:49 a.m., the hearing was concluded.]

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